[Product Name]

[Anthem Bronze Guided Access with HSA – cacc]

[Anthem Bronze Guided Access with HSA – caav]

[Anthem Bronze Guided Access – cabk]

[Anthem Bronze Guided Access – caaq]

[Anthem Bronze Guided Access with Child Dental – cdaq]

[Anthem Silver Guided Access with HSA – cbbk]

[Anthem Silver Guided Access with HSA - cbbl]

[Anthem Silver Guided Access with HSA – cbbm]

[Anthem Silver Guided Access with HSA – cbbn]

[Anthem Silver Guided Access – cbdk]

[Anthem Silver Guided Access – cbdl]

[Anthem Silver Guided Access – cbdm]

[Anthem Silver Guided Access – cbdn]

[Anthem Gold Guided Access – ccaj]

[Anthem Gold Guided Access with Child Dental – cdcx]

[Anthem Catastrophic Guided Access]

[Anthem Native American Guided Access]

[Anthem Blue Cross and Blue Shield Silver GuidedAccess, a Multi-State Plan]

[Anthem Blue Cross and Blue Shield Gold GuidedAccess, a Multi-State Plan]

CERTIFICATE OF COVERAGE

THIS CERTIFICATE IS ALSO AVAILABLE AS A CHILD ONLY [POLICY OR CONTRACT].

This Certificate is Guaranteed Renewable subject 24-A M.R.S.A. s 2850-B.

If you do not purchase pediatric dental coverage through this plan you must purchase a stand-alone pediatric dental plan.

Introduction

Welcome to Anthem Blue Cross and Blue Shield! This Certificate has been prepared by Us to help explain your coverage. Please refer to this Certificate whenever you require medical services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

This Certificate, the application, and any amendments or riders attached shall constitute the entire Certificate under which Covered Services and supplies are provided by Us.

This Certificate should be read and re-read in its entirety. Since many of the provisions of this Certificate are interrelated, you should read the entire Certificate to get a full understanding of your coverage.

Many words used in the Certificate have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the Definitions section for the best understanding of what is being stated.

This Certificate also contains “Noncovered Services/Exclusions,” so please be sure to read this Certificate carefully.

Benefit Program

The benefits, terms and conditions of this Certificate are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Claims Information

For questions about Covered Services or claims, please call a Customer Service Representative at the number on your ID card. Be sure to have your identification number ready when you call so We can answer your questions promptly.

Your Rights and Responsibilities

As a Member You have certain rights and responsibilities to help make sure that You get the most from this Plan. It helps You know what You can expect from Your overall health care benefit experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with Your doctors and other health professionals about all health care options and treatment needed for Your condition, no matter what the cost or whether it is covered under this Plan.

- Work with Your doctors in making choices about Your health care.
- Be treated with respect and dignity.
- Privacy of Your personal health information, as long as it follows state and Federal laws and Our privacy policies.
- Get information about Our company and services, and Our network of doctors and other health care Providers.
- Get more information about Your Rights and Responsibilities and give Us Your thoughts and ideas about them.
- Give Us Your thoughts and ideas about any of the rules of this Plan and in the way it works.
- Make complaints or appeal about: Our organization, any benefit or coverage decisions We make, Your coverage, or care received.
- Say no to any care, for any condition, sickness or disease, without it affecting any care You may get in the future; and the right to have Your doctor tell You how that may affect Your health now and in the future.
- Get all of the most up-to-date information about the cause of Your illness, Your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that You will not be able to understand certain information, that information will be given to someone else that you choose.

You have the responsibility to:

- Choose a network Primary Care Physician (doctor), also called a PCP, if Your Plan requires it.
- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with Your health care Providers and call their office if You have a delay or need to cancel.
- Read and understand, to the best of Your ability, all information about Your health benefits or ask for help if You need it.
- To the extent possible, understand Your health problems and work with Your doctors or other health care professionals to make a treatment plan that You all agree on.
- Give Us, Your doctors and other health care professionals the information needed to help You get the best possible care and all the benefits You are entitled to. This may include information about other health coverage and insurance benefits You have in addition to Your coverage with Us.
- Tell Your doctors or other health care professionals if You don't understand any care You are getting or what they want You to do as part of Your care plan.
- Follow the care plan that You have agreed on with your Doctors and other health care professionals.
- Follow all Plan rules and policies.
- Let Our customer service department know if You have any changes to Your name, address or Dependents covered under Your Certificate.

If you have any questions or need additional information, call customer service at 1-877-890-4507.

How to Get Language Assistance

Anthem is committed to communicating with Our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of

Our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

10 Day Certificate Review

This Certificate replaces any previous Certificates issued by Us.

Services provided during an inpatient stay that started during an existing Certificate will continue to be covered by the terms of that Certificate until you are discharged or reach any of the Certificate's limits or maximums, whichever occurs first.

If you decide not to accept this Certificate, return it to our home office (Anthem Blue Cross and Blue Shield; 2 Gannett Drive; South Portland, ME 04106-6911) within 10 days after its delivery date. Please include a written request to cancel it. We will then refund any Subscription Charges less any claims paid under this Certificate.

"

Kathleen S. Kiefer
Corporate Secretary

TABLE OF CONTENTS

Summary of Benefits

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Exclusions" section.

Services will only be Covered Services if rendered by Providers located in Maine unless:

- **The services are for Emergency Care, Urgent Care and ambulance services; or**
- **The services are approved in advance by Anthem.**

What will I pay?

This chart shows the most you pay for Deductibles and out-of-pocket expenses for Covered Services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance , including 0% Coinsurance, except for Network Preventive Care Services required by law.

	Member			
	In-Network		**Out-of-Network**	
	Per Individual	**Per Family**	**Per Individual**	**Per Family**
Medical Deductible	$[0][3500][5900][5000][6000][3000][2250][1150][500][2500][750][200][1250][6,350]	$[0][7000][11800][10000][12000][6000][4500][2300][2,500][1000][5000][4500][1500][400][12,700]	$[0][7,000] [11,800] [10,000] [12,000] [6,000] [5,000] [12,700]	$[0][14,000] [23,600] [20,000] [24,000] [12,000] [10,000] [25,400]
Coinsurance	[0][5][10][20][25]%		[0][20][25][30][40]%	
Out-of-Pocket Limit	$[0][6000][3950][3500][1150][500][4500][1500][650][6,350]	$[0][12000][7800][7000][1000][2,300][12000] 9000][3000][1300][12,700]	$[0][10500][17700][15000][18000][10000][19050]	$[0][21,000] [35,400] [30,000] [36,000] [20000][38100][35,100]

[Note: All Members share one common Deductible.

Note: All Members share one common Out-of-Pocket Maximum.]

[Note: No one Member can accumulate more than the Individual Deductible. All Members accumulate to the family Deductible.

Note: No one Member can accumulate more than the Individual Out-of-Pocket. All Members accumulate to the family Out-of-Pocket Limit.]

	In-Network		**Out-of-Network**	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Ambulance Services (emergent)	$[0]	[0][5][10][20][25]%	$[0]	[0][5][10][20][25]%
Applied Behavior Analysis [1,450 15-minute sessions or 360 hourly sessions]	$[0][10][25][30][40]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%
Chiropractic (Physical Manipulations/Adjustments) 40-visits per calendar year Network and Non-Network combined.	$[0][10][25][30][40]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%

[**Doctor visits** Primary Care Physician	$[0][10][25][30][40] for the first [2][3] visits, then Network Deductible and Coinsurance.	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%
Specialty Care Provider	$[0]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%]
[**Doctor visits** Primary Care Physician	$[0][10][25][30][40]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%
Specialty Care Provider	$[0]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%]
[**Doctor visits** Primary Care Physician	$[0][10][25][30][40] [Deductible waived]	[0]%	$[0]	[0][20][25][30][40]%
Specialty Care Provider	$[0]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%]

Durable Medical Equipment (non-preventive)	$[0][10][25][30][40]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%
Early Intervention Services	$[0][10][25][30][40]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%
Emergency room visits (copay waived if admitted)	$[200][100][75][0]	[0][5][10][20][25]%	$[200][100][75][0]	[0][20][25][30][40]%
Urgent Care	$[50][25][0]	[0][5][10][20][25]%	$[50][25][0]	[0][20][25][30][40]%
Hearing Aid One hearing aid per Member up to age of [18] for each hearing impaired ear every [36] months	$[0][10][25][30][40]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%
Home Health Care	$[0][10][25][30][40]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%
Hospital Services (for all scheduled inpatient admissions you must call for a Prior Authorization)				
Inpatient	$[0][150][250][500]	[0][5][10][20][25]%	$[0][180][200][600]	[0][20][25][30][40]%
Outpatient	$[0]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%
Inborn Errors of Metabolism metabolic formula coverage of special modified low-protein food products. Please refer to you certificate for additional information.	$[0][10][25][30][40]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%
Mental Health & Substance Abuse				
Inpatient	$[0][150][250][500]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%
Outpatient	$[0][10][25][30][40]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%
Outpatient Diagnostic tests				

Laboratory	$[0][10][25][30][40]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%
MRI, CT, & PET scan	$[0][10][25][30][40]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%
Radiology	$[0][10][25][30][40]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%
Outpatient Therapy Services Cardiac visits up to [36] visits per cardiac episode per Member per Calendar Year. Physical, Occupational and Speech Therapy up to [60] visits per Member per Calendar Year combined.	$[0][10][25][30][40]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%
Preventive Care Please see “Preventive Care” in your Certificate for additional information.	$[0]	[0]%	$[0]	[0][20][25][30][40]%
Prosthetics for limb replacement (deductible does not apply).	$[0]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%
Skilled Nursing Care	$[0]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%
Surgery	$[0]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%
Telemedicine	$[0][10][25][30][40]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%

[**Dental Care (Pediatric)** The following dental benefits are available for Covered Services received from a Network provider for Members through age 18. Please see the Dental Care in the Covered Services section of this document for detailed descriptions of services.	
Annual Maximum per Member	$[0]
Annual Deductible per Member	$[0][50]

	Coinsurance	
	Network	Non-Network

Diagnostic and Preventive Services	[0]%	[0][30][Not Covered]%
Basic Restorative Services	[0][40]%	[0][50][Not Covered]%
Oral Surgery Services	[0][50]%	[0][50][Not Covered]%
Endodontic	[0][50]%	[0][50][Not Covered]%
Periodontal Services	[0][50]%	[0][50][Not Covered]%
Major Restorative Services	[0][50]%	[[0]50][Not Covered]%
Prosthodontic Services	[0][50]%	[0][50][Not Covered]%
Orthodontic Services	[0][50]%	[0][50][Not Covered]%]

	In-Network		**Out-of-Network**	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
[Prescription Drugs Certain contracted Maine retail pharmacies can fill your prescription at the same copayments that apply to the mail service pharmacy level of benefits. Please ask your pharmacy if they offer this special arrangement or call our Customer Service Department at the phone number on your ID card for a list of retail pharmacies that offer the mail service pharmacy level of benefits.				
Retail (30-day supply)				
Tier One	$[0][10][15][20]	0%	$0	[0][20][25][30][40]%
Tier Two	$[0][25][35][40]	0%	$0	[0][20][25][30][40]%
Tier Three	$0	[0][5][10][20][25]%	$0	[0][20][25][30][40]%
Tier Four (Tier Three and Four subject to Medical Deductible.)	$0	[0][5][10][20][25]%	$0	[0][20][25][30][40]%
Mail Order				
Tier One (up to 90 day supply)	$[0][20][30[40] $[62.50][87.5	0%	$0	[0][20][25][30][40]%

	In-Network		**Out-of-Network**	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Tier Two (up to 90 day supply) Tier Three (up to 90 day supply) Tier Four (up to 30 day supply) (Tier Three and Four subject to Medical Deductible.)	0][100][0] $0 Not Covered	0% [0][5][10][20][25]% Not Covered	$0 $0 Not Covered	[0][20][25][30][40]% [0][20][25][30][40]% Not Covered]

	In-Network		**Out-of-Network**	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
[Prescription Drugs Certain contracted Maine retail pharmacies can fill your prescription at the same copayments that apply to the mail service pharmacy level of benefits. Please ask your pharmacy if they offer this special arrangement or call our Customer Service Department at the phone number on your ID card for a list of retail pharmacies that offer the mail service pharmacy level of benefits.				
[Retail (30-day supply) and Mail Order (90 day supply)	$[0]	[0][5][10][20][25]%	$[0]	[0][20][25][30][40]%]

Vision Care (Pediatric)

Pediatric Essential Health Benefits

The following benefits are available to members through age 18.

	In Network Copayment	**Out-of-Network Payment Allowance**
Routine Eye Exam	$[0]	$[30]
[1] every Calendar Year		
Standard Plastic Lenses*		
[1] every Calendar Year		
Single Vision	$[0]	$[25]
Bifocal	$[0]	$[40]
Trifocal	$[0]	$[55]

Progressive	$[0]	$[40]
Note: Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost.		
Frames* (formulary) This plan offers a selection of covered frames.	$[0]	$[45]
[1] every Calendar Year		
Contact Lenses*(formulary) This plan offers a selection of covered contact lenses.		
Elective (conventional and disposable)	$[0]	$[60]
Non-Elective	Covered in full	$[210]
[1] every Calendar Year]		

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

The Non-Network payment allowance is the amount the plan will pay for the services.

[**Note:** Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal Organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these Providers.]

Section One - Eligibility and Termination of Coverage

The benefits terms and conditions of this Certificate are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Subscriber

To be eligible for membership as a Subscriber under this Certificate, the applicant must:

1. Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP.
2. Be a United States citizen or national; or
3. Be a lawfully present non-citizen for the entire period for which coverage is sought; and
4. Be a resident of the State of Maine; and meet the following applicable residency standards;

   For a Qualified Individual age 21 and over, the applicant must:

   - Not be living in an institution
   - Be capable of indicating intent
   - Not be receiving optional State supplementary payments (SSP): and
   - Reside in the Service Area of the Exchange

   For a Qualified Individual under age 21, the applicant must:

   - Not be living in an institution
   - Not be eligible for Medicaid based on receipt of federal payments for foster care and adoption assistance under Social Security
   - Not be emancipated
   - Not be receiving optional State supplementary payments (SSP); and
   - Reside in the Service Area of the Exchange,
5. Agree to pay for the cost of the Subscription Charge;
6. Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
7. Not be incarcerated (except pending disposition of charges)
8. Not be entitled to enroll in Medicare Part A without payment of the Subscription Charge,
9. Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, a Qualified Individual's service area is the area in which the Qualified Individual:

1. Resides, intends to reside (including without a fixed address); or
2. Is seeking employment (whether or not currently employed); or
3. Has entered without a job commitment.

For Qualified Individuals under age 21, the service area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with Members in multiple Exchange Service Areas:

1. If all of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the tax filers meets the residency requirements.
2. If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a tax dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the dependent meets a residency standard.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, be determined by the Exchange to be a Qualified Individual, meet all Dependent eligibility criteria and be:

1) The Subscriber's legal spouse.
2) The Subscriber's Domestic Partner - Domestic Partner or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.
   - For purposes of this Certificate, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.
   - A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.
   - To apply for coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated on the Enrollment Application and submit the Enrollment Application to the Exchange. The Exchange will make the ultimate decision in determining eligibility of the Domestic Partner.
3) The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children who are under age 26.
4) Children for whom the Subscriber or the Subscriber's spouse is a legal guardian and who is under age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Exchange must certify the Dependent's eligibility. The Exchange must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the Dependent would normally become ineligible. You must notify the Exchange if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Exchange may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Certificate.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Certificate unless required by the laws of this state.

Open Enrollment

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by the Exchange.

American Indians are authorized to move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a QHP through the Exchange, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has 60 calendar days from the date of a triggering event to select a QHP.

The Exchange must allow Qualified Individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

- A Qualified Individual or dependent loses Minimum Essential Coverage;
- A Qualified Individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;
- An individual, not previously a citizen, national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or HHS, or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming Plan Year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A Qualified Individual or enrollee gains access to new QHPs as a result of a permanent move; and
- A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide.

Qualified Individuals are free to move between metal levels during special enrollment periods.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Exchange a form to add the child under the Subscriber's Certificate. The form must be submitted along with the additional Subscription Charge, if applicable, within 60 days after the birth of the child. A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

The Newborn of a Member who is a Dependent child is eligible for benefits for Covered Services only from the moment of birth up to and including 31 days immediately following birth, but is not eligible for enrollment beyond this 31 day period under the Certificate until and unless the Subscriber is appointed by a court as legal guardian and can offer proof of such legal guardianship.

Adding a Child due to Award of Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Certificate must be submitted to the

Exchange within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under this Certificate, and the child is otherwise eligible for the coverage, you must request permission from the Exchange for your child to enroll under this Certificate, and once approved by the Exchange We will provide the benefits of this Certificate in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any Dependent Age Limit listed in the Summary of Benefits. Any claims payable under this Certificate will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year for a Qualified Individual who has made a QHP selection during the annual open enrollment period. A Subscriber's actual Effective date is determined by the date he or she submits a complete application to the Exchange.

Effective dates for special enrollment periods:

1. In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption. Advance Payments of the Premium Tax Credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and
2. In the case of marriage, or in the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month.

Effective dates for Loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1. Legal separation or divorce;
2. Cessation of dependent status, such as attaining the maximum age;
3. Death of an employee;
4. Termination of employment;
5. Reduction in the number of hours of employment; or
6. Any loss of eligibility for coverage for any of the following;
    - Individual who no longer resides, lives or works in Anthem service area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

Effective dates for Loss of Minimum Essential Coverage does not include termination or loss due to:

1. Failure to pay Subscription Charges on a timely basis, including COBRA Subscription Charges prior to expiration of COBRA coverage, or
2. Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Certificate. The Exchange must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify the Exchange of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of Subscription Charges for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Exchange must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms or as otherwise required by the Exchange. Such notifications must include all information required to effect the necessary changes.

A Member's coverage terminates on the date such Member ceases to be eligible for coverage. The Plan has the right to bill the Subscriber for the cost of any services provided to such person during the period such person was not eligible under the Subscriber's coverage.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Exchange applications or other forms or statements the Exchange may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Exchange is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Certificate are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card for each Member and a Certificate for each Subscriber.

Termination

This Section describes how coverage for a Member can be cancelled, rescinded, suspended or not renewed.

Termination of the Member

The Member's coverage will terminate if any of the following occurs:

1. The Member terminates his/her coverage with appropriate notice to the Exchange or the QHP.
2. The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date).

3. The Member fails to pay his or her Subscription Charge, and the grace period has been exhausted.
4. Rescission of the Member's coverage.
5. The QHP terminates or is decertified.
6. The Member changes to another QHP; or
7. The QHP may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP as required by law.

Grace Period refers to either:

1. the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit; in this case, the last day of coverage will be the last day of the first month of the 3-month grace period; or
2. the grace period required under Maine Law.

Effective Dates of Termination

Termination of coverage is effective on the following date(s):

1) In the case of termination initiated by the Member, the last day of coverage is:
   - The termination date specified by the Member, if reasonable notice is provided;
   - Fourteen days after the termination is requested, if the Member does not provide reasonable notice; or
   - On a date determined by the Member's QHP issuer, if the Member's QHP issuer is able to implement termination in fewer than fourteen days and the Member requests an earlier termination effective date.
2) If the Member is newly eligible for Medicaid, CHIP, or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3) In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination effective date.
4) In the case of a termination for non-payment of the Subscription Charge and the 3-month grace period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period.
5) In the case of a termination for non-payment of the Subscription Charge, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day of the grace period.
6) In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
7) The day following the Member's death. When a Subscriber dies, the surviving spouse or Domestic Partner of the deceased Subscriber, if covered under the Certificate, shall become the Subscriber.

Reasonable notice is defined as fourteen days prior to the requested effective date of termination

Guaranteed Renewable

Coverage under this Certificate is guaranteed renewable, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Certificate by payment of the renewal Subscription Charge by the end of the grace period of the Subscription Charge due date, provided the following requirements are satisfied:

1. Eligibility criteria as a Qualified Individual continues to be met;

2. There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Certificate; and
3. This Certificate has not been terminated by the Exchange.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish to the Exchange or the QHP any information requested regarding your eligibility and the eligibility of your Member dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Subscription Charge or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Certificate, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your Member dependents did not disclose on the application, We may rescind this Certificate as of the original Effective Date. Additionally, if within two (2) years after adding an additional dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your Member dependents did not disclose on the application, We may rescind coverage for the additional Member dependent as of his or her original Effective Date. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage. You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Subscription Charge paid for such services.

This Certificate may also be terminated if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Certificate. Termination for any act, practice or omission that constitutes fraud or any intentional misrepresentation of material fact will be effective as of the Effective Date of coverage in the case of rescission. We will give you at least 30 days written notice prior to rescission of this Certificate. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of the Health Coverage

We can refuse to renew your Certificate if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide you with at least 90 days notice of the discontinuation. In addition, you will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Nonrenewal will not affect an existing claim.

Grace Period

If the Subscriber does not pay the full amount of the Subscription Charge by the Subscription Charge due date, the grace period is triggered. The grace period is an additional period of time during which coverage remains in effect and refers to either the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit (APTC) or for individuals not receiving the APTC it refers to any other applicable grace period.

If the Subscriber does not pay the required Subscription Charge by the end of the grace period, the Certificate is cancelled. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC

If the Subscriber receiving the APTC has previously paid at least one month's Subscription Charge in a Benefit Period, We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If the full Subscription Charge is not received during the grace period, the last day of coverage will be the latter of the last day of the first month of the 3-month grace period or the last day through which Subscription Charge is paid. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to Anthem's right to cancel the Certificate as provided herein.

Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Certificate has a grace period of 30 days. This means if any Subscription Charge, except the first, is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Certificate will stay in force unless prior to the date Subscription Charge is due You give timely written notice to Us that the Certificate is to be cancelled. If you do not pay the full Subscription Charge during the grace period, the Certificate will be cancelled on the last day of the grace period. You will be liable to Us for the Subscription Charge due including those for the grace period. You will also be liable to Us for any claims payments made for services incurred after the grace period.

Cancellation

Once this Certificate is cancelled, the Subscriber cannot reapply until the next annual open enrollment unless there is an event that qualifies for a special enrollment prior to the annual open enrollment period. You have the right to designate another person to receive notice of cancellation of this Certificate for nonpayment of charges or other lapse or default. We will send the notice to you and the person you designate at the last addresses you provided to Us 10 calendar days prior to cancellation of the contract. You also have the right to change the person you designate if you wish. In order to designate a person to receive this notice or to change a designation, you must fill out a Third Party Notice Request Form. You can obtain this form by contacting Us.

Removal of Members

A Subscriber may cancel the enrollment of any Member from the Certificate. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

Right to Reinstatement

You may be eligible to reinstate the Certificate within 90 days after the date of cancellation if non-payment of charges or other lapse or default took place because you suffered from cognitive impairment or functional incapacity at the time of cancellation. For the purposes of this provision, cognitive impairment or functional incapacity means a mental or nervous disorder of demonstrable origin that causes significant impairment.

If you request reinstatement, We may require a physician examination at your own expense or request medical records that confirm you suffered from cognitive impairment or functional incapacity at the time of cancellation. If We accept the proof, We will reinstate your coverage without a break in coverage. We will reinstate the same coverage you had before cancellation or the coverage you would have been entitled to if the Certificate had not been canceled, subject to the same terms, conditions, exclusions, and limitations. Before We can reinstate your Certificate, you must pay the amount due from the date of

cancellation through the month in which We bill you within 15 days from Our request. The charges will be the same amount they would have been if the Certificate had remained in force.

If We deny your request for reinstatement, We will send you a Notice of Denial. You have the right to an Appeal, or to request a hearing before the Superintendent of Insurance within 30 days after the date you receive the Notice of Denial from Us.

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Certification of Prior Creditable Coverage

If your coverage is terminated, you and your Member dependents will receive a certification showing when you were covered under the Certificate. You may need the document to buy, for yourself or your family, other health coverage. Certifications may be requested within 24 months of losing coverage.

You may also request a certification be provided to you at any other time, even if you have not lost coverage under this Certificate. If you have any questions, contact the customer service telephone number listed on the back of your Identification Card

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Section Two - Utilization Management

All services you receive are subject to the provisions in this section. Failure to comply with any or all of the requirements listed below will result in a denial or reduction of your benefits. If you have any questions, please call the number on the back of your Identification Card.

If you have a health concern, please contact your physician.

The purpose of Utilization Management is to review your medical care and determine if you are receiving medically necessary inpatient and outpatient services. The program includes an ongoing monitoring of your health care needs and possible assignment of a care manager to work with you and your physician to optimize your benefits.

This review is to determine financial reimbursement if the requested benefit is a Covered Service. The decision for treatment is solely between the patient and physician, regardless of the decision made regarding financial reimbursement.

None of Our employees or the providers We contract with to make medical management decisions are paid or provided incentives to deny or withhold benefits for services that are medically necessary and are otherwise covered under the Certificate. In addition, We require members of Our clinical staff to sign an annual statement. This statement verifies that they are not receiving payments that would either encourage or reward them for denying benefits for services that are medically necessary and are otherwise covered under the Certificate.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services. In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply. Just because Anthem exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Insured. Anthem may stop or modify any such exemption with or without advance notice. You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service.

Anthem Medical Policy

The purpose of medical policy is to assist in the interpretation of Medical Necessity. However, the Certificate takes precedence over medical policy. Medical technology is constantly changing and We reserve the right to review and update medical policy periodically.

Requesting Approval for Benefits

Your Plan includes the processes of precertification, predetermination and post service clinical claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered.

Prior Authorization: Network Providers must obtain prior authorization in order for you to get benefits for certain services. prior authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was prescribed or asked for is not Medically Necessary if you have not first tried other Medically Necessary and more cost effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination** – An optional, voluntary prospective or continued stay review request for a benefit coverage determination for a service or treatment. We will check your Certificate to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Certificate or is Experimental/Investigative as that term is defined in this Certificate.

- **Post Service Clinical Claims Review** – A retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a predetermination review performed. Medical Reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Typically, Network Providers know which services need precertification and will get any precertification or ask for a predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with us to ask for a precertification or predetermination review ("requesting Provider"). We will work with the requesting Provider for the precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services given by a Network Provider	**Services given by a BlueCard/Out-of-Network/Non-Network Provider**
Provider	• Member must get Precertification. • If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. • For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any medically necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigational as that term is defined in the Plan otherwise .Your Certificate take precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which We based Our determination. To ask for this information, call the precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Insured. Anthem may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at the number on your identification card.

Request Categories

- **Emergent** – A request for precertification or predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment, seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for precertification or predetermination that is conducted before the service, treatment or admission.

- **Continued Stay Review** - A request for precertification or predetermination that is conducted during the course of treatment or admission.

- **Retrospective** - A request for approval that is made after the service, treatment or admission has happened. post service clinical claims reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, We will follow state laws. If you live in and/or get services in a state other than the state where your Certificate was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
Prospective Emergent	48 hours after receiving all necessary information
Prospective Non-Emergent	2 working days after receiving all necessary information
Continued Stay Review when hospitalized at the time of the request	1 working day after receiving all necessary information prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	1 working day after receiving all necessary information
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	1 working day after receiving all necessary information
Continued Stay Review Non-Emergent	1 working day after receiving all necessary information
Retrospective	30 calendar days after receiving all necessary information

If more information is needed to make Our decision, We will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If We do not get the specific information We need or if the information is not complete by the timeframe identified in the written notice, We will make a decision based upon the information we have.

We will give notice of Our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice (followed by written notice) given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. The Subscription Charge must be paid for the time period that services are given;
3. The service or supply must be a covered benefit under your Certificate;
4. The service cannot be subject to an Exclusion under your Certificate; and
5. You must not have exceeded any applicable limits under your Certificate.

Individual Case Management

Care Management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Care Management Program to help meet their health-related needs.

Our Care Management programs are confidential and voluntary. These programs are given at no extra cost to you.

If you meet program criteria and agree to take part, We will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen representative, treating Doctor(s), and other Providers.

In addition, We may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service through Our case management program. We may also extend Covered Services beyond the benefit maximums of this Certificate. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify you or your representative in writing.

Members' Rights and Responsibilities

You have the right to:

- Request in writing a copy of Our clinical review criteria used in arriving at any denial or reduction of benefits;
- Appeal any adverse determinations based on medical necessity;
- Refuse treatment for any condition, illness, or disease without jeopardizing future treatment.

Second Surgical Opinion

Second surgical opinion is an opinion given by a network board certified surgeon when your doctor recommends surgery. It is important to note that although you may receive a second surgical opinion, the choice of having the surgery is always yours.

To receive benefits for a second surgical opinion, you must receive approval from Us prior to seeking the second surgical opinion. We pay up to the Maximum Allowable Amount for second surgical opinions. Deductibles and Coinsurance do not apply to this benefit. For approval of a second surgical opinion, call toll-free customer service number on the back of your ID card.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

See your Plan's directory of In-Network Providers at [**www.anthem.com**], which lists the Doctors, Providers, and Facilities that participate in this Plan's network.

Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.

Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

Option for states that require narrow network disclosure: Please note that We have several networks, and that a Provider that is In-Network for one plan may not be In-Network for another. Be sure to check your Identification Card or call Customer Service to find out which network this Plan uses.

Your Primary Care Physician

Choosing Your Primary Care Physician (PCP)

Each family member must choose a Primary Care Physician from Our directory of Network Providers. Family members can choose the same Primary Care Physician or different ones. A Directory of PCPs is available on Our website at www.anthem.com or by calling Our Customer Service department at the number on your ID card.

To receive maximum benefits for Covered Services, you must follow the terms of the Certificate, including, if applicable, receipt of care from your Primary Care Physician, use of Network Providers, and obtaining any required prior authorization. Regardless of Medical Necessity, no payment will be provided for care that is not a Covered Service even if performed by your PCP.

We recognize the following as Primary Care Physicians:

Family Practitioner A family practitioner is a Physician who specializes in the primary health care of people of all ages. Some family practitioners also provide maternity and general surgical care.

Pediatrician A pediatrician is a Physician who specializes in the primary health care of infants, children, and adolescents. Some pediatricians also treat young adults.

Internist An internist is a Physician who specializes in the primary health care of young adults and adults. Some internists also treat adolescents.

Obstetrician/Gynecologist (OB/GYN) An OB/GYN is a Physician who specializes in women's reproductive health and childbearing. In order to be a Primary Care Physician an OB/GYN must meet certain requirements, and agree to provide all primary care.

Qualified Certified Nurse Practitioners or other qualified primary care providers, as required by law, for services within the scope of their license.

It is important for you to consider the specialty and location of your primary care physician when choosing.

Responsibilities of Your Primary Care Physician

Your PCP provides and coordinates your overall health care. When you need medical services, contact your PCP. He or she will usually provide the care, such as routine physical examinations, treatment of sickness or injury and administration of medically necessary injections and immunizations. When your PCP determines that you need specialized care, he or she will refer you to a Network specialist or coordinate any Hospital care you may need.

You do not need to obtain a referral or approval from your PCP to see a Specialist or an Obstetrician/Gynecologist (OB/GYN).

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,

- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you have any questions about Covered Services, call us at the telephone number listed on the back of your Identification Card.

Changing Your Primary Care Physician

If you or a Dependent wish to change PCPs, you may call Us to obtain a change form. You may also change your PCP over the telephone by calling a Customer Service Representative at the telephone number on your ID card.

When you change PCPs, the change is effective on the first day of the month after: 1) your change form is received and accepted; or 2) you call to request the change.

If your Primary Care Physician's participation in this Network ends, We will notify you and will furnish you with a list of Primary Care Physicians so you can choose a new one. If you do not choose a new Primary Care Physician within the specified time, We may assign a Primary Care Physician of the same specialty (if available) for you. If your Primary Care Physician unexpectedly withdraws from the Network, you may be assigned a temporary Primary Care Physician until you choose a new one.

Continuity of Care

If you are undergoing a course of treatment and the treating Provider withdraws from this Network, we will notify you of the termination. You may be allowed to continue receiving care from the withdrawing Provider for a period of 60 days from the date of notice of termination or through the end of postpartum care if you are in the second trimester of a pregnancy, if the Provider:

- Agrees to accept the same rates of reimbursement that were in effect prior to the date of termination;
- Agrees to adhere to Our applicable quality assurance standards and to provide Us with the necessary medical information related to the care provided you; and
- Agrees to adhere to Our policies and procedures.

Maintaining the Patient-Physician Relationship

Members enroll in this plan with the understanding that the Primary Care Physician is responsible for determining appropriate treatment for the Member. For personal or religious reasons, some Members may disagree with the treatment recommended by the Primary Care Physician. They may demand treatment that the Primary Care Physician or We judge to be incompatible with proper medical care. In the event of such disagreement, Members have the right to refuse the recommendation of the Primary Care Physician. Members who do not adhere to recommended treatment or who use non-recognized sources of care because of such disagreement, do so with the full understanding that We have no obligation for the costs of such non-authorized care.

Relationship of Network Providers

We contract with a select group, or Network, of Providers to provide you with health care services. These Providers are not Our employees. In their agreements with Us, Network Providers agree to be responsible for the health care services provided to Members according to quality assurance and Utilization Management standards. Under both the terms and conditions of this Certificate, and Our agreements with Network Providers, We pay for Covered Services determined to be appropriate by Our Utilization Management standards.

Emergency Care In or Outside of the Service Area

This plan provides benefits for health care services received in an emergency care facility or setting. To receive benefits for emergency care services, you must have symptoms of sufficient severity that a prudent lay person would reasonably expect that the absence of immediate medical attention could result in serious physical and/or mental jeopardy; serious impairment to body functions; or serious dysfunction to any body organ or part.

In emergency situations, you should seek immediate medical attention. We cover Emergency Services necessary to screen and stabilize, without prior authorization from your Primary Care Physician, only if a prudent lay person acting reasonably would have believed that an Emergency Medical Condition existed. You should contact your Primary Care Physician within 48 hours of receiving Emergency Services, or as soon as possible after emergency screening and stabilization have taken place, for appropriate follow-up care, if needed. Benefits for emergency care may be denied if your Primary Care Physician, applying the prudent lay person guideline, determines that your symptoms did not indicate that Emergency Services were necessary. If you disagree with the medical judgment of your Primary Care Physician, and feel that your Emergency Services should be authorized, you have the right to Appeal that decision, as outlined in the “Benefit Determinations, Payments and Appeals” section of this Certificate.

Follow-up visits and elective and routine procedures are not covered unless performed by or authorized in advance by your Primary Care Physician.

If you are traveling outside of Maine and you need urgent care, you can call your PCP or you can call the telephone number on your ID card for direction. You will be responsible for Copayments, just as you would if you received care within the Network. Any follow-up care should be coordinated with your PCP once you return home.

Members at School Outside of Their Service Area

If you require Emergency Services while you are outside your Service Area enrolled as a full-time student at a school or college, We will provide benefits for Covered Services in a Physician’s office, clinic, or Hospital. You should seek emergency care services just as you would at home or inside your Service Area.

For non-emergency care, you should seek care and send the itemized bill with a short letter of explanation to Our Customer Service Department. The letter must indicate that services were for a student away at school. Follow-up visits and elective and routine procedures are not covered unless performed by or authorized in advance by your Primary Care Physician.

Network Provider Unavailable

If you are unable to obtain services from a Network Provider, you or your doctor should call the telephone number on your ID card. Our care managers will work with you or your doctor to locate a Network Provider. If it is determined by the care manager that no Network Provider is available, We will authorize Covered Services from a Non-Network Provider. Benefits will be reimbursed at the higher network level with no balance billing.

Section Three - Covered Services

This section, along with the "Exclusions" section, explains health care services for which We will and will not provide benefits. All Covered Services are subject to the Deductibles, Coinsurance, maximums, exclusions, limitations, terms, provisions and conditions of this Certificate, including any attachments and amendments or riders. Benefits for Covered Services are based on the Maximum Allowable Amount. To receive maximum benefits for Covered Services, you must follow the terms of the Certificate, including, use of Network Providers and obtaining any required prior authorization. **Services will only be Covered Services if rendered by Providers located in Maine unless: 1. the services are for Emergency Care, Urgent Care and ambulance services; or 2.the services are approved in advance by Anthem.**

Our payment for Covered Services will be limited by any applicable Deductible or annual maximum. Please see the "Utilization Management" section for conditions that apply to all inpatient admissions.

Benefits for Covered Services may be payable subject to an approved treatment plan. Only medically necessary health care is covered. Although We do not provide benefits for Covered Services that do not meet Our definition of medical necessity, you and your physician must decide what care is appropriate. The fact that a physician may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment. If you choose to receive care that is not a covered service or does not meet Our definition of medical necessity, We will not provide benefits for it. Anthem bases its decisions about referrals, prior authorization, medical necessity, experimental services and new technology on medical policy developed by Anthem. Anthem may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Unless specifically stated otherwise, all benefits, limitations and exclusions under this Certificate apply separately to each covered family member.

A Member's right to benefits for Covered Services provided under this Certificate is subject to certain policies or guidelines and limitations, including, but not limited to, Anthem Medical Policy, Continued Inpatient Stay Review, Pre-admission Review, Post-Admission Review, and Prior Authorization. A description of each of these guidelines explaining its purpose, requirements and effects on benefits is provided in the "Utilization Management" section. Failure to follow the Utilization Management guidelines for obtaining Covered Services will result in reduction or denial of benefits.

Allergy Testing and Injections

We provide benefits for allergy testing and injections.

Ambulance Service (Air, Ground and Water)

We provide benefits for Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
    1) From your home, scene of accident or medical Emergency to a Hospital;
    2) Between Hospitals, including when We require you to move from an Out-of-Network Hospital to an In-Network Hospital; or
    3) Between a Hospital, Skilled Nursing Facility (ground transport only) or Approved Facility.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases We may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals during an ambulance service, even if You are not taken to a Facility.

Out-of-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to medical necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance provider.

Ambulatory Surgery Centers We provide benefits for certain Covered Services provided by ambulatory surgery centers. Covered services vary according to the scope of an individual facility's licensure.

Anesthesia Services We provide benefits for anesthesia only if administered while a covered service is being provided, except as outlined in the 'Dental Procedures' provision. We do not provide benefits for local or topical anesthesia unless it is part of a regional nerve block.

Asthma Education We provide benefits for approved asthma education programs for Our covered Members with asthma and their families. Benefits are provided when the program is received from an approved Network Provider. Please call Us for a listing of approved Providers.

Autism Spectrum Disorders We provide coverage for Members who are five years of age or under for any assessments, evaluations or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an Autism Spectrum Disorder. Treatment of Autism Spectrum Disorders is covered when it is determined by a licensed physician or licensed psychologist that the treatment is Medically Necessary Health Care, as defined in the Certificate of Coverage. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage at least annually.

Please refer to your Summary of Benefits for limits that may apply.

Blood Transfusions We provide benefits for blood transfusions including the cost of blood, blood plasma, and blood plasma expanders, and administrative costs of autologous blood pre-donations.

Chemotherapy Services We provide benefits for antineoplastic drugs and associated antibiotics and their administration when they are administered by parenteral means such as intravenous, intramuscular, or intrathecal means. This does not include the use of drugs for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS unless approved by Us for medically accepted indications or as required by law. Any FDA Treatment Investigational New Drugs are not covered unless approved by Us for medically accepted indications or as required by law.

Chiropractic Care We provide benefits for chiropractic care. See the "Manipulative Therapy" provision for additional information.

Clinical Trials We provide benefits for services related to Clinic Trial Costs.

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
    a) The National Institutes of Health.
    b) The Centers for Disease Control and Prevention.
    c) The Agency for Health Care Research and Quality.
    d) The Centers for Medicare & Medicaid Services.
    e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to Our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve Our right to exclude any of the following services

i. The Investigational item, device, or service, itself; or
ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Contraceptives We provide benefits for prescription contraceptives approved by the federal Food and Drug Administration (FDA) and on Our Generic based Formulary to prevent pregnancy, including related consultations, examinations, procedures, and medical services provided on an outpatient basis. Contraceptives are covered under the Preventive benefit. Please see the Preventive and Well-Care Services section in this Certificate.

Dental Procedures We will provide benefits for general anesthesia and associated facility charges for dental procedures rendered in a hospital when the Member is classified as vulnerable. Examples of vulnerable Members include, but are not limited to the following:

- Infants
- Individuals exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result
- Individuals with acute infection
- Individuals with allergies
- Individuals who have sustained extensive oral-facial or dental trauma
- Individuals who are extremely uncooperative, fearful or anxious

Dental Services (Adults) We provide Benefits only for the following:

- Setting a jaw fracture
- Removing a tumor (but not a root cyst)
- Treatment within six months of an accidental injury to repair or replace natural teeth or within six months of the effective date of coverage, whichever is later
- Repairing or replacing dental prostheses caused by an accidental bodily injury within six months of the injury or within six months of the effective date of coverage, whichever is later.

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[Optional Language]

Covered Pediatric Dental Care

All covered services are subject to the terms, limitations, and exclusions of your Certificate. See your "Summary of Benefits" for your cost share amounts, such as deductibles and/or any coinsurance.

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are medically necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Certificate. We evaluate the procedures submitted to Us on your claim to determine if they are a covered service under this Certificate.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section "Orthodontic Care" for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Certificate. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Certificate. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any coinsurance or deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Certificate benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Certificate may affect Our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

Description of Covered Services for Pediatric Members

We cover the following dental care services for members up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations - Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

NOTE: Comprehensive oral evaluations will be covered 1 time per dental office, subject to the 2 times per calendar year limitation. Any additional comprehensive oral evaluations performed by the same dental office will be covered as a periodic oral evaluation and will be subject to the 2 times per calendar year limitation.

Radiographs (X-rays)

- Bitewings - Covered at 1 series of bitewings per 6-month period.
- Full Mouth (Complete Series) - Covered 1 time per 60-month period.
- Panoramic – covered 1 time per 60-month period.
- Periapical(s) - 4 single x-rays are covered per 12-month period.
- Occlusal - Covered at 2 series per 24-month period.

Interpretation of diagnostic images by a practitioner not associated with capture of the image, including report.

Dental Cleaning (Prophylaxis) – Any combination of this procedure and Periodontal Maintenance (See Periodontal Services) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) - Covered 2 times per 12-month period.

Fluoride Varnish - Covered 2 times per 12-month period for children through the age of 18.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered 1 time per 36-month period for permanent first and second molars.

Basic Restorative Services

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Consultations (other than dentist providing treatment)

Amalgam (silver) Restoration. Treatment to restore decayed or fractured permanent or primary posterior (back) teeth.

Composite (white) Resin Restorations. Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

LIMITATION**:** Coverage for amalgam or composite restorations will be limited to 1 service per tooth surface per 24-month period.

Space Maintainers - Covered 1 time per lifetime for extracted primary posterior (back) teeth.

Recement Space Maintainer.

Basic Extractions

Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth

Extraction of erupted tooth or exposed root

Other Adjunctive General Services.

Therapeutic drug injection, by report

Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

Pulpal Therapy

Therapeutic Pulpotomy

Endodontic Therapy on Permanent Teeth

Root Canal Therapy

Root Canal Retreatment

LIMITATION: All of the above procedures are covered 1 time per tooth per lifetime.

Other Endodontic Treatments – Limited to once per tooth per lifetime.

Pulpal regeneration

- Apexification
- Apicoectomy
- Root amputation
- Hemisection
- Retrograde filling

Periodontal Services

Periodontal Maintenance - A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed previous surgical or nonsurgical periodontal treatment.

LIMITATION: Any combination of this procedure and dental cleanings (see Diagnostic and Preventive section) is covered 4 times per calendar year.

Basic Non Surgical Periodontal Care - Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planing - Covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to 1 time per 24 months.
- Full mouth debridement - Covered 1 time per lifetime.

Crown Lengthening – Covered once per lifetime.

Complex Surgical Periodontal Care - Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

LIMITATION: Only 1 complex surgical periodontal service is covered per 36-month period per single tooth or multiple teeth in the same quadrant and only if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

LIMITATION: Surgical removal of 3rd molars is only covered if the removal is associated with symptoms or oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

LIMITATION: The above procedures are covered only when required to prepare for dentures and is a benefit covered once in a 60-month period.

Other Oral Surgery Procedures.

- Incision and drainage of abscess (intraoral soft tissue)
- Collect – apply autologous product
- Excision or pericoronal gingival
- Coronectomy
- Tooth reimplantation – accidentally evulsed or displaced tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation and General Anesthesia – Covered only when given with covered complex surgical services.

Major Restorative Services

Inlays - Benefit will equal an amalgam (silver) restoration for the same number of surfaces.

LIMITATION**:** If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the maximum allowed amount for the amalgam restoration and the inlay, plus any deductible and/or coverage percentage that applies.

Pre-fabricated or Stainless Steel Crown - Covered 1 time per 60-month period.

Onlays and/or Permanent Crowns - Covered 1 time per 5 years if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only.

LIMITATION: We will pay up to the maximum allowed amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any deductible and/or coverage percentage that applies.

Implant Crowns - See Prosthodontic Services.

Recement Inlay, Onlay and Crowns - Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair - Covered 1 time per 12-month period per tooth when the submitted narrative from the treating dentist supports the procedure.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface - Covered 1 time per 5 years when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Resin infiltration/smooth surface.

Prefabricated post and core in addition to crown – covered 1 per tooth every 60 months.

Occlusal Guards – Covered 1 per 12 months for members age 13 through 18.

Prosthodontic Services

Tissue Conditioning - Covered 1 time per 24-month period.

Reline and Rebase - Covered 1 time per 36-month period:

- When the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- Only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) - Covered 1 time per 12 month period:

- When the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- Only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.
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Denture Adjustments - Covered 2 times per 12-month period:

- When the denture is the permanent prosthetic appliance; and
- Only after 6 months following initial placement of the denture.

Partial and Bridge Adjustments - Covered 2 times per 24-month period:

- When the partial or bridge is the permanent prosthetic appliance; and
- Only after 6 months following initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) - Covered 1 time per 5 year period:

- For covered persons age 16 or older;
- For the replacement of extracted (removed) permanent teeth;
- If 5 years have elapsed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) - Covered 1 time per 5 year period:

- For covered persons age 16 or older;
- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have elapsed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.
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LIMITATION: If there are multiple missing teeth, a removable partial denture may be the benefit since it would be the least costly, commonly performed course of treatment. The optional benefit is subject to all contract limitations on the covered service.

Recement Fixed Prosthetic - Covered 1 time per 12 months.

Single Tooth Implant Body, Abutment and Crown - Covered 1 time per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

LIMITATION: Some adjunctive implant services may not be covered. It is recommended that a pretreatment estimate be requested to estimate the amount of payment prior to beginning treatment.

Orthodontic Care

Orthodontic Treatment is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover orthodontic care that is Dentally Necessary Orthodontic Care. You should submit your treatment plan to Us before you start any orthodontic treatment to make sure it is covered under this Certificate.

Dentally Necessary Orthodontic Care

To be considered Dentally Necessary Orthodontic Care, at least one of the following criteria must be present:

- There is spacing between adjacent teeth which interferes with the biting function;
- There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
- Positioning of the jaws or teeth impair chewing or biting function;
- On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
- Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

Orthodontic treatment may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts/models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Complex Surgical Procedures – surgical exposure of impacted or unerupted tooth for orthodontic reasons; or surgical repositioning of teeth.
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Note: Treatment in progress (appliances placed prior to being covered under this Certificate) will be benefited on a pro-rated basis.

Orthodontic Exclusions

Coverage is NOT provided for:

- Monthly treatment visits that are inclusive of treatment cost;
- Repair or replacement of lost/broken/stolen appliances;
- Orthodontic retention/retainer as a separate service;
- Retreatment and/or services for any treatment due to relapse;
- Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
- Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, payments are made over the course of your treatment. You must have continuous coverage under this Certificate in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this coverage ends.

Before treatment begins, the treating dentist should submit a pre-treatment estimate to Us. An Estimate of Benefits form will be sent to you and your dentist indicating the estimated maximum allowed amount, including any amount (coinsurance) you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the dentist should submit the Estimate of Benefit form with the date of appliance placement and his/her signature. After benefit and eligibility verification by Us, a payment will be issued. A new/revised Estimate of Benefits form will also be issued to you and your dentist. This again will serve as the claim form to be submitted 6 months from the date of appliance placement.

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Diabetic Services We provide benefits for diabetes medication and supplies which are medically appropriate and necessary. Medication encompasses insulin, insulin pumps, and oral hypoglycemic agents. Covered supplies and equipment are limited to glucose monitors, test strips, syringes and lancets. Covered Services also include outpatient self-management and educational services used to treat diabetes if services are provided through a program that is approved by the State's Diabetes Control Project within the Bureau of Health. Screening for gestational diabetes is covered under the “Preventive and Well-Care services” provision in this Certificate.

Diagnostic Services We provide benefits for diagnostic services, including diagnostic laboratory tests and x-rays, when they are ordered by a professional to diagnose specific signs or symptoms of an illness or injury or when the services are part of well-baby or well-adult care stated as covered under this contact.

You must receive prior authorization from Us for the advanced diagnostic imaging services which include but are not limited to:

CT Scans, MRI/MRAs, Nuclear Cardiology, and PET Scans.

Please call the number on the back of your Identification Card if you have questions regarding which services require prior authorization.

Durable Medical Equipment and Prostheses If more than one treatment, prosthetic device, or piece of durable medical equipment may be provided for your disease or injury, benefits will be based on the least expensive method of treatment, device, or equipment that can meet your needs.

Durable Medical Equipment We provide benefits for the rental or purchase of durable medical equipment. Whether you rent or buy the equipment, we provide benefits for the least expensive equipment necessary to meet your medical needs. If you rent the equipment, We will make monthly payments only until Our share of the reasonable purchase price of the least expensive equipment is paid or until the equipment is no longer necessary, whichever comes first.

Benefits for replacement or repair of purchased durable medical equipment are subject to Our approval. We do not provide benefits for the repair or replacement of rented equipment.

Supplies are covered if they are necessary for the proper functioning of the durable medical equipment. Supplies for durable medical equipment are not subject to any durable medical equipment maximum applicable to this plan.

Prostheses We provide benefits for prostheses. Prostheses include artificial limbs and prosthetic appliances. Prostheses to replace limbs (ie: arms or legs) are not subject to the plan Deductible. All other prostheses are subject to the Deductible. Coverage for repair and replacement if the repair or replacement of the prostheses is determined appropriate by the enrollee's Provider .

Early Intervention Services We provide benefits for early intervention services for Members from birth to age 36 months with an identified developmental disability or delay. A referral from the Child's primary care provider is required. Please refer to your Summary of Benefits for Cost-Shares and Limits.

Emergency Room Care We provide benefits for emergency room treatment received for medical emergencies. You or a designated person should contact your physician and Anthem within 48 hours from the time you receive care.

Family Planning We provide benefits for family planning. See the "Contraceptives" provision within this section for details.

Foot Care We provide benefits for podiatry services, including systemic circulatory disease. Routine foot care is not covered.

Freestanding Imaging Centers We provide benefits for diagnostic services performed by freestanding imaging centers. All services must be ordered by a professional. You must receive prior authorization from Us for the advanced diagnostic imaging services which include but are not limited to:

CT Scans, MRI/MRAs, Nuclear Cardiology, and PET Scans.

Please call the number on the back of your Identification Card if you have questions regarding which services require prior authorization.

Hearing Care We provide benefits for wearable hearing aids for covered Members up to age 18. Coverage is limited to one hearing aid per Member for each hearing impaired ear every 36 months. Related items such as batteries, cords, and other assistive listening devices, including but not limited to, frequency modulation systems, are not covered. A hearing aid is defined as a wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing.

Home Health Care Services We provide benefits for home health care services when services are performed and billed by a home health care agency. A home health care agency must submit a written plan of care, and then provide the services as approved by Us. Please see your Summary of Benefits for Cost-Shares and Limits.

We provide benefits for the following home health care services:

- Physician home and office visits;
- Registered nurse (RN) or licensed practical nurse (LPN) nursing visits;
- Services of home health aides when supervised by an RN;

- Paramedical services, including physical therapy, speech therapy, occupational therapy, inhalation therapy, and nutritional guidance;
- Supportive services, including prescription drugs, medical and surgical supplies, and oxygen.

Home Infusion Therapy We provide benefits for home infusion therapy when provided and billed by a Home Infusion Therapy provider. Supplies and equipment needed to appropriately administer home infusion therapy are covered.

Hospice Care Services We provide benefits for hospice care. Hospice care are those covered services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Benefits for details on the payment levels and limits for services and supplies listed below.

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care. .
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition including oxygen and related respiratory therapy supplies.
- Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the member's death. Bereavement services are available to surviving covered family members.

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 12 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to Us upon request.

Additional covered services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional covered services, which are described in other parts of this certificate, are provided as set forth in other parts of this certificate.

Hospice Respite Care We provide benefits for up to a 48-hour period for respite care. Respite care is intended to allow the person who regularly assists the patient at home, either a family member of other nonprofessional, to have personal time solely for relaxation. The patient may then need a temporary replacement to provide hospice care. Before the patient receives respite care at home, a home health agency must submit a plan of care for approval.

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and

including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Donor benefits are limited to benefits not available to the donor from any other source.

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Contact the Case Manager for specific Network Transplant Provider information for services received at or coordinated by a Network Transplant Provider Facility. Services received from a Non-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by a Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work up services at a Network Transplant Facility will maximize your benefits.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant workup and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be

allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

- Non-Covered Services for transportation and lodging include, but are not limited to:
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices, ; and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the mobilization, harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

Helpful tip: See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inborn Errors of Metabolism We provide benefits for metabolic formula for special modified low-protein food products. They must be specifically manufactured for patients with diseases caused by inborn errors of metabolism. This benefit is limited to those Members with diseases caused by inborn errors of metabolism.

Independent Laboratories We provide benefits for diagnostic services performed by independent laboratories. All services must be ordered by a professional.

Infant Formula We provide benefits for Medically Necessary Amino Acid-based elemental Infant Formula for children 2 years of age and under. Benefits are provided when a licensed physician has diagnosed and through medical evaluation has documented one of the following conditions:

- Symptomatic allergic colitis or proctitis;
- Laboratory – or biopsy-proven allergic or eosinophilic gastroenteritis;

- A history of anaphylaxis'
- Gastroesophageal reflux disease that is nonresponsive to standard medical therapies;
- Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by medical provider;
- Cystic fibrosis; or
- Malabsorption of cow milk-based or soy milk-based infant formula.

Benefits for amino acid-based elemental infant formula are provided when a licensed physician has submitted documentation that the amino acid-based elemental infant formula is medically necessary health care as defined in section 4301-A subsection 10-A, that the amino acid based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated. A licensed physician may be required to confirm and document ongoing Medical Necessity at least annually.

Coverage for amino acid-based elemental infant formula must be provided without regard to the method of delivery of the formula.

Prior Authorization is required. Please see the "Utilization Management" section of this document for more information.

Inhalation Therapy We provide benefits for inhalation therapy by a licensed therapist for the administration of medications; gases such as oxygen, carbon dioxide, or helium; water vapor; or anesthetics.

Inpatient Hospice Services We Provide benefits for inpatient hospice care at an acute care hospital or skilled nursing facility. The same services are covered for inpatient hospice care as are covered under inpatient hospital services.

Inpatient Hospital Services We provide benefits for the following inpatient hospital services:

- Room and board, including general nursing care, special duty nursing, and special diets. Please see your Summary of Benefits for Cost-Shares and Limits.;
- Use of intensive care or coronary care unit;
- Delivery of a newborn (please see "Maternity Care" provision below for more information)
- Diagnostic services;
- Medical, surgical, and central supplies;
- Treatment services;
- Hospital ancillary services including but not limited to use of operating room, anesthesia, laboratory, x-ray, and inpatient occupational therapy, physical therapy, inhalation therapy, and radiotherapy services;
- Phase I Cardiac Rehabilitation;
- Medication used when you are an inpatient, such as drugs, biologicals, and vaccines. This does not include the use of drugs for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS unless approved by us for medically necessary accepted indications or as required by law. Any FDA Treatment Investigational New

Drugs are not covered unless approved by Us for medically accepted indications or as required by law;

- Blood and blood derivatives;
- Prostheses or orthotic devices;

Benefits for an inpatient stay in a hospital will end with the earliest of the following events:

- You are discharged as an inpatient;
- You reach any Certificate limits or maximums;
- Your physician, hospital personnel, or We notify you that inpatient care no longer meets Our guidelines for continued hospital admission.

Manipulative Therapy We provide benefits for therapeutic adjustments and manipulations for treating acute musculo-skeletal disorders. No benefits are provided for ancillary treatment such as massage therapy, heat and electrostimulation unless in conjunction with an active course of treatment. Benefits are not provided for maintenance therapy for chronic conditions (see Chiropractic Care above). Please see your Summary of Benefits for Cost-Shares and Limits.

Massage Therapy We provide benefits for massage therapy when services are part of an active course of treatment and the services are performed by a covered provider.

Maternity Care We provide benefits for prenatal and postnatal care, delivery of a newborn, care of a newborn, therapeutic abortion and complications of pregnancy. When no complications are present, the postpartum hospital stay ranges from 48 hours for vaginal delivery to 96 hours for cesarean birth, excluding the day of delivery. Routine newborn care does not include any services provided after the mother has been discharged from the hospital. All other plan provisions such as Deductible and Coinsurance, if applicable, will apply to the newborn if the mother is discharged and the newborn remains in the hospital. We do not provide benefits for routine circumcisions. Please see your Summary of Benefits for Cost-Shares and Limits.

Medical Care We provide benefits for medical care and services including office visits and consultations, hospital and skilled nursing facility visits, and pediatric services.

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Medical Supplies We provide benefits for medical supplies furnished by a Provider in the course of delivering medically necessary services. This benefit does not apply to bandages and other disposable items that may be purchased without a prescription, except for syringes which are medically necessary for injecting insulin or a drug prescribed by a physician.

Mental Health and Substance Abuse Services We provide benefits for inpatient, outpatient, and day treatment services for mental health and substance abuse when you receive them from a provider. You will receive maximumbBenefits for mental health services when you receive care from Network Providers.

The "Utilization Management" section contains additional information and requirements for mental health and substance abuse services. If you do not call for preadmission review for nonemergency inpatient mental health and substance abuse services, your benefits will be reduced by as much as $500 per admission.

If you receive provider services from a community mental health center or substance abuse treatment facility, services must be:

- Supervised by a licensed physician, licensed clinical psychologist, or licensed clinical social worker; and
- Part of a plan of treatment for furnishing such services established by the appropriate staff member.

We provide benefits for only the following mental health and/or substance abuse treatment services:

- Room and board, including general nursing;
- Prescription drugs, biologicals, and solutions administered to inpatients;
- Supplies and use of equipment required for detoxification and rehabilitation;
- Diagnostic and evaluation services;
- Intervention and assessment;
- Facility-based professional and ancillary services;
- Individual, group and family counseling;
- Psychological testing;
- Emergency treatment for the sudden onset of a mental health or substance abuse condition requiring immediate and acute treatment.
- Intervention and assessment.

Listed Mental Illnesses: State of Maine Statute requires that benefits be provided at the same benefit level provided for medical treatment, including but not limited to the following listed mental illnesses: Psychotic disorders, including schizophrenia; dissociative disorders; mood disorders; anxiety disorders; personality disorders; paraphilias; attention deficit and disruptive behavior disorders; pervasive developmental disorders; tic disorders; eating disorders, including bulimia and anorexia; and substance abuse-related disorders.

Please see your Summary of Benefits for Cost-Shares and Limits for inpatient, outpatient and office visits for mental health and substance abuse services.

Morbid Obesity-We provide limited Benefits for treatment of Morbid Obesity if you are diagnosed as morbidly obese for a minimum of five consecutive years. Benefits are limited to surgery for an intestinal bypass, gastric bypass, or gastroplasty. Prior authorization is required. We do not provide Benefits for weight loss medications.

Nutritional Counseling We provide benefits for nutritional counseling when required for a diagnosed medical condition.

Obstetrical Services and Newborn Care We provide benefits for prenatal and postnatal care, delivery of a newborn, care of a newborn and complications of pregnancy. We do not provide benefits for routine circumcisions.

Office Visits We provide benefits for office visits. If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Online Visits When available in your area, you coverage will include online visit services. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice.

Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

Orthotic Devices We provide benefits for certain orthotic devices, such as orthopedic braces, back or surgical corsets, and splints. We do not provide benefits for the following whether available over the counter or by prescription: arch supports, shoe inserts, other foot support devices, orthopedic shoes (unless attached to a brace), support hose, and garter belts.

Outpatient Services We provide benefits for the following hospital outpatient and rural health center services:

- Emergency room services/emergency care;
- Removal of sutures;
- Application or removal of a cast;
- Diagnostic services;
- Surgical services;
- Removal of impacted or unerupted teeth;
- Endoscopic procedures;
- Blood administration;
- Radiation therapy;
- Outpatient rehabilitation programs including covered Phase II cardiac rehabilitation, physical rehabilitation, head injury rehabilitation, pulmonary rehabilitation, and dialysis training. Benefits for these services have special requirements. Please check with Us to see if you are eligible for benefits;
- Outpatient educational programs such as diabetes education. Please check with Us to see if you are eligible for benefits.

Parenteral and Enteral Therapy We provide benefits for parenteral and enteral therapy. Supplies and equipment needed to appropriately administer parenteral and enteral therapy are covered. Nutritional supplements for the sole purpose of enhancing dietary intake are not covered unless they are given in conjunction with enteral therapy.

Prescription Drugs We provide benefits for:

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third or fourth “tier” Drug. Refer to your Summary of benefits to determine your copayment, coinsurance and deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our

discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

> **Note:** Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy benefits manager from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy benefits manager.

Prescription Drug List

We also have a Prescription Drug List, (a formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by Us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by Our Members, and where proper, certain clinical economic reasons.

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

We retain the right, at Our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Your Benefit Program limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This formulary contains a limited number of prescription drugs, and may be different than the formulary for other Anthem products. Generally, it includes select generic drugs with limited brand prescription drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete prescription drugs from this formulary from time to time. A description of the prescription drugs that are listed on this formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration)

Where You Can Obtain Prescription Drugs

Your Benefit Program includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of

Retail Pharmacies, Mail Service Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Certain contracted Maine retail pharmacies can fill your prescription at the same copayments that apply to the mail service pharmacy level of benefits. Please ask your pharmacy if they offer this special arrangement or call our Customer Service Department at the phone number on your ID card for a list of retail pharmacies that offer the mail service pharmacy level of benefits.

Retail

You can visit one of the local Retail Pharmacies in Our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. Refer to your Summary of Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain prescription drugs. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

> **Helpful tip:** Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Administered by a Medical Provider" benefit. Please read that section for important details.

Mail Order

Your Mail Order Prescription Drug program is administered by Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (maintenance medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Summary of Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain prescription drugs.

> **Helpful Tip**: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

The first mail order Prescription you submit must include a completed patient profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

You can have your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver your specialty Drugs to you by mail or common carrier for self administration in your home. You cannot pick up your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get prior authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your specialty drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Important Details About Prescription Drug Coverage

Your Benefit Program includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require prior authorization. Also, a Participating Pharmacist can help arrange prior authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of

Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details We need to decide if prior authorization should be given. We will give the results of Our decision to both you and your Provider.

If prior authorization is denied you have the right to file a Grievance as outlined in the "Grievance and External Review Procedures" section of this Booklet.

For a list of Drugs that need prior authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Benefit Program. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or generic Drugs are covered under the Benefit Program.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before We will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Administered by a Medical Provider

Your Benefit Program also covers Prescription Drugs when they are administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the "Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

> **Helpful tip**: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit. Also, if Prescription Drugs are covered under the Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, they will not be covered under this benefit.

Prescription Drug Continuity If you have been undergoing a course of treatment with a prescription drug that has been prior authorized by your prior carrier, you may continue with that prescription drug until we conduct a review of the prior authorization with your Provider. Anthem has the right to request a review with your prescribing Provider. We will honor the prior carrier's prior authorization for a period up to 6 months if your Provider participates in the review and requests the prior authorization be continued. We are not required to provide benefits for conditions or services not otherwise covered under our Certificate, and cost sharing may be based on the copayments and coinsurance requirements of this Certificate.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected “once daily dosage” Drugs on Our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a “½ tablet daily.” The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to Network rates for drugs not listed on Our formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
2 Gannett Drive; South Portland, ME 04106-6911
Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Maine – 1-(800) 477-4864

Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210

Home Office Address You may visit our home office during normal business hours at:
2 Gannett Drive; South Portland, ME 04106-6911

Preventive and Well-Care Services

We provide benefits for the following preventive and well-care services. Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this policy with no deductible, co-payments or coinsurance from the Member as explained in your Certificate. That means Anthem pays 100% of the Maximum Allowed Amount. When you receive Covered Services from a Non-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s charge unless Anthem has authorized Covered Services from a Non-Network Provider due to Provider Network inadequacies.

These services fall under four broad categories as shown below:

1) Services with an “A” or “B” rating from the United States Preventive Services Task Force.
    - Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High Blood Pressure;
    - Type 2 Diabetes Mellitus;
    - Cholesterol;

- Child and Adult Obesity;
- Gestational diabetes screenings.

2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration including:
    - Counseling and screening for HIV in sexually active women;
    - breast pumps (supplies, rental and purchase) one per Calendar Year as required by law;
    - counseling during pregnancy to help promote breastfeeding;
    - counseling for sexually transmitted infections and domestic violence;
    - womens contraceptives, sterilization procedures and counseling.

You may call Customer Service using the number on your ID card for additional information about these services.

We provide benefits for:

Well-baby/child care:

- Prenatal care;
- Initial hospital care;
- Well-child care including standard routine pediatric immunizations

Please see your Summary of Benefits for Well baby/child care exam schedule.

Well-adult care:

- Screening mammograms for women (benefits are limited to two radiographic views per breast);
- Screening for cervical cancer and Pap tests performed by a physician, certified nurse practitioner, or certified nurse midwife when recommended by a physician;
- Gynecological examinations, including routine pelvic and clinical breast examinations performed by a physician, certified nurse practitioner or certified nurse midwife;
- Prostate specific antigen testing and digital rectal examinations;
- Colorectal cancer screening.
- Smoking Cessation
- Counseling and screening for HIV
- Sexually Transmitted Infection (STI) prevention counseling
- Diet counseling for adults at higher risk for chronic disease

Note: Screenings and other services are generally covered as Preventive Care for adults and children with no current signs or symptoms of a medical condition. Members who have current symptoms of a

medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit and subject to the coinsurance and /or deductible applicable to your plan.

Radiation Therapy We provide benefits for radiation therapy.

Reconstructive Surgeries, Procedures and Services Benefits are available for reconstructive surgeries, procedures and services, when considered to be Medically Necessary Health Care, only if at least one of the following criteria is met. Reconstructive surgeries, procedures and services must be:

- necessary due to accidental injury; or
- necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or
- Medically Necessary Health Care to restore or improve a bodily function, or
- necessary to correct a birth defect for covered dependent children who have functional physical deficits due to the birth defect. Corrective surgery for children who do not have functional physical deficits due to the birth defect is not covered under any portion of this Certificate
- for reconstruction of a breast on which mastectomy surgery has been performed and for surgery and reconstruction of the other breast to produce a symmetrical appearance.

Reconstructive surgeries, procedures and services that do not meet at least one of the above criteria are not covered under any portion of this Certificate.

In addition to the above criteria, benefits are available for certain reconstructive surgeries, procedures and services subject to Anthem Medical Policy coverage criteria. Some examples of reconstructive surgeries, procedures and services eligible for consideration based on Anthem Medical Policy coverage criteria are:

- Mastectomy for Gynecomastia
- Mandibular/Maxillary orthognathic surgery
- Port Wine Stain surgery

Skilled Nursing Facility Services We provide benefits for inpatient skilled nursing facility services. Please see your Summary of Benefits for Cost-Shares and limits. We do not cover custodial confinement.

Speech, Physical and Occupational Therapy We provide benefits for short-term speech, physical and occupational therapy on an outpatient basis for conditions that are subject to significant improvement. Please see your Summary of Benefits for Cost-Shares and Limits.. Services are covered only when provided by a licensed professional acting within the scope of his/her license.

No benefits are provided for treatments such as: massage therapy, paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment.

No benefits are provided for speech therapy for deficiencies resulting from mental retardation, or dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors

Surgical Services Benefits are provided for covered surgical procedures, including services of a surgeon, specialist, anesthetist or anesthesiologist, and for preoperative and postoperative care.

For covered surgeries, services of surgical assistants are payable as a surgery benefit if included on the list of payable Anthem surgical assistant codes. If you have questions about your surgical procedure, please contact your physician or Customer Service.

Telemedicine Benefits are provided for telemedicine if the health care service would be covered were it provided through in-person consultation between the covered person and a covered health care Provider. Coverage for health care services provided through telemedicine will be determined in a manner consistent with coverage for health care services provided through in-person consultation.

Vision Care We will cover vision care that is listed in this section through the age 18. See your Summary of Benefits for the benefit frequencies and your cost share amounts for covered vision care. We will not pay for vision care listed in the Exclusion section.

Routine Eye Exam

Your Certificate covers a complete eye exam with dilation as needed. The exam is used to check all aspects of your vision, including the structure of the eyes and how well they work together.

Eyeglass Lenses

You have a choice in your eyeglass lenses. Lenses include factory scratch coating at no additional cost.

- Covered eyeglass lenses include standard plastic (CR39) lenses up to 55 mm in:
- single vision
- bifocal
- trifocal (FT 25-28)
- progressive (for members through age 18)

Frames*

Elective Contact Lenses*

Elective contact lenses are contacts that you choose instead of eyeglasses comfort or appearance. You may choose elective contact lenses in lieu of your eyeglass lenses benefit.

Non-Elective Contact Lenses*

- Non-elective contacts are only provided for the following medical conditions:
- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent.
- Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses and frames until you satisfy the benefit frequency listed in the Summary of Benefits.

SPECIAL NOTE: We will not reimburse for Non-Elective Contact Lenses for any member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

Section Four – Exclusions

This section, along with the "Covered Services" section, explains the types of health care services We will and will not provide benefits for. Charges you pay for services related to non-covered services do not count toward any Deductible, Coinsurance, or out-of-pocket limits. The exclusions listed below are in addition to those set forth elsewhere in this Certificate. We do not cover services for the following:

1) Biofeedback - We do not provide benefits for biofeedback.
2) Blood - We do not provide Benefits for any blood, blood donors, or packed red blood cells when participation in a voluntary blood program is available.
3) Department of Veterans Affairs - We do not provide Benefits for any treatments, services, or supplies provided to veterans by the Department of Veterans Affairs, its Hospitals, or facilities if the treatment is related to your service connected disability.
4) Facilities of the Uniformed Services - We do not provide Benefits for any treatments, services, or supplies provided by or through any health care facility of the uniformed services. This exclusion does not apply if you are a military dependent or retiree.
5) Family Planning Services - We do not provide Benefits for services to reverse voluntarily induced sterility; non-prescriptive birth control preparations (such as foams or jellies); and over-the-counter contraceptive devices.
6) Genetic Testing and Counseling - We do not provide Benefits for genetic testing or genetic counseling to diagnose a condition. Genetic testing and counseling performed on a previously diagnosed patient is covered only if the genetic testing and counseling is required to plan treatment of the diagnosed condition.
7) Leased Services and Facilities - We do not provide Benefits for any health care services or facilities that are not regularly available in the Provider you go to, that the Provider must rent or make special arrangements to provide, and that are billed independently.
8) Mental Health, Substance Abuse Treatment and Lifestyle Services - We do not provide Benefits for any of the following services or any services relating to:
    - Sensitivity training;
    - Encounter Groups;
    - Educational programs except as indicated in the "Covered Services" section;
    - Marriage, guidance, and career counseling;
    - Codependency;
    - Adult Children of Alcoholics (ACOA);
    - Pain control (except as required by law for Hospice Care services);
    - Activities whose primary purpose is recreational and socialization.
9) Orthognathic Surgery - We do not provide Benefits for Orthognathic Surgery, except as stated in the Covered Services, Reconstructive Surgeries, Procedures and Services section.
10) Physical and Occupational Therapy - We do not provide Benefits for massage therapy, treatment such as paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment.
11) Routine Circumcisions We do not provide Benefits for routine circumcisions.
12) Services by Ineligible Providers - We do not provide Benefits for services provided by any Provider not listed as an eligible Provider in this Contract.
13) Services Not Listed As Covered - We do not provide Benefits for any service, procedure, or supply not listed as a Covered Service in this Contract.
14) Services Related to Non-Covered Services - We do not provide Benefits for services related to any non-Covered Service or to any complications and conditions resulting from any non-Covered Service.
15) Shoe Inserts - We do not provide Benefits for shoe inserts.
16) Speech Therapy - We do not provide Benefits for deficiencies resulting from mental retardation and/or dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors.

17) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.
18) Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy
19) for court ordered testing or care, unless the service is Medically Necessary and authorized by Us.
20) We do not pay services, supplies, etc. for for the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
    - Care provided or billed by residential treatment centers or facilities, unless those centers or facilities are required to be covered under state law. This includes but is not limited to individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
    - Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.
    - Wilderness camps.

    The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.
21) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
22) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.
23) For examinations relating to research screenings.
24) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
25) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
26) For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
27) In excess of Our Maximum Allowable Amounts.
28) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.
29) For which you have no legal obligation to pay in the absence of this or like coverage.
30) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Certificate or as required by law.
31) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.
32) Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
    - Surcharges for furnishing and/or receiving medical records and reports.
    - Charges for doing research with Providers not directly responsible for your care.
    - Charges that are not documented in Provider records.

- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers.Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

33) for Private Duty Nursing Services unless specifically stated in the Covered Services section
34) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.
35) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.
36) For self-help training and other forms of non-medical self care, except as otherwise provided herein.
37) Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions unless in conjunction with an active course of treatment.
38) For treatment of telangiectatic dermal veins (spider veins) by any method.
39) For Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.
40) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Certificate or as required by law.
41) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.
42) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.
43) Services, supplies, and equipment for the following:
    - Hippotherapy.
    - Prolotherapy.
    - Recreational therapy.
44) For Ambulance, We do not provide benefits for Ambulance usage when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non Covered Services for Ambulance include but are not limited to, trips to:
    - A Physician's office or clinic;
    - A morgue or funeral home.
    - Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or Your home.
45) For in home Hospice Care, We do not provide benefits for the following services, supplies or care:
    - Services or supplies for personal comfort or convenience, including homemaker services.
    - Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
    - Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
    - • Services provided by volunteers.
46) For Prescription Drugs, we do not provide Benefits for the following:
    - Administration Charges Are charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
    - Clinically-Equivalent Alternatives Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

- Contrary to Approved Medical and Professional Standards Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by us.
- Drugs Over the Quantity Prescribed or Refills After One Year Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Medical Supplies Oral immunizations and biologicals, even if they are federal legend Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- Items Covered Under the "Allergy Services" Benefit Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit.
- Lost or Stolen Drugs Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless we must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescriptions drugs used to treat infertility

47) Your Vision care services do not include:
We will not pay for services incurred for, or in connection with, any of the items below.

- Vision care for members age 19 and older, unless covered by the medical benefits of this Policy.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a member receives the benefits in whole or in part. This exclusion also applies whether or not the member claims the benefits or compensation. It also applies whether or not the member recovers from any third party.

- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the member's immediate family, including the member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this booklet or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Policy.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Policy.
- Lost or broken lenses or frames, unless the member has reached the member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Policy.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- For Members through age 18, no benefit is available for frames that are identified by the Provider as premium designer collections.

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[Optional Language]

48) Dental Care coverage is NOT provided for (unless otherwise included under Covered Services)::

- Dental care for members age 19 and older.
- Dental services which a member would be entitled to receive for a nominal charge or without charge if this coverage were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a member receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this [plan/policy] will not be reduced or denied because dental services are rendered to a subscriber or dependent who is eligible for or receiving medical assistance.

- Dental services or health care services not specifically covered under the [plan/policy] (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).
- New, experimental or investigational dental techniques or services may be denied until there is, to our satisfaction, an established scientific basis for recommendation.
- Dental services completed prior to the date the member became eligible for coverage.
- Services of anesthesiologists.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Dental services performed other than by a licensed dentist, licensed physician, his or her employees.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Case presentations.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Athletic mouth guards, enamel microabraision and odontoplasty.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the [policy/plan].
- Bacteriologic tests. Please refer to your medical coverage to determine if this is a covered medical benefit.
- Cytology sample collection. Please refer to your medical coverage to determine if this is a covered medical benefit.
- Separate services billed when they are an inherent component of another covered service.
- Services for the replacement of an existing partial denture with a bridge.
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Provisional splinting, temporary procedures or interim stabilization.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital. Please refer to your medical coverage to determine if this is a covered medical benefit.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Incomplete root canals.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Amalgam or composite restorations, inlays, onlays and/or crowns placed for preventive or cosmetic purposes.

- Temporomandibular Joint Disorder (TMJ) except as covered under your medical coverage.
- Oral hygiene instructions.
- Repair or replacement of lost/broken appliances are not a covered benefit.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.

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Section Five - Benefit Determinations, Payments and Appeals

Benefit Determinations

We, or anyone acting on Our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms of the Certificate. However, We, or anyone acting on Our behalf will determine the administration of your benefits. . You may utilize all applicable Complaint and Appeal procedures, as outlined later in this section if you do not agree with Our determination.

You may have some responsibility for the cost of health services under your Certificate. Your responsibility may take the form of a Coinsurance percentage or a Deductible amount. Please see the "Covered Services" section for the Copayment, Coinsurance and Deductible amounts that apply to your coverage. If you have some responsibility for the cost of health care services you receive, you will pay your Coinsurance and Deductible amount directly to the professional or hospital or other provider of care.

All benefits for Covered Services will be based on any discounted charge for hospital service or Our Maximum Allowable Amount for professional services.

If you have Coinsurance responsibility that is based on a percentage, you will pay your Coinsurance percentage based on the hospital's or provider's discounted charge or negotiated amount, or Our Maximum Allowable Amount for professionals.

We may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include, but is not limited to, prescription drugs, mental health, behavioral health and substance abuse services. Such subcontracted organizations or entities may make Benefit determinations and/or perform administrative, claims paying, or customer service duties on our behalf.

Benefit Levels There is one level of benefit under this Certificate:

> **Network Providers** If your claim from a Network Provider is approved, We will pay benefits directly to the Network Provider. Except for Deductibles and Coinsurance, you are not required to pay any balances to the Provider for Covered Services until after We determine the benefits We will pay.

How Your Deductible Works

Deductible is the dollar amount of Covered Services listed in the Summary of Benefits for which you are responsible before We start to pay for Covered Services subject to the Deductible in each Calendar Year.

Deductible and Coinsurance, if applicable, will apply to a newborn if the mother is discharged and the newborn remains in the hospital.

Coinsurance

For some services, your share of the cost is a percentage which is limited to an annual dollar amount. This is the Coinsurance amount. Please see your Summary of Benefits for Cost-Shares and Limits.

Your Certificate has a Coinsurance requirement, it applies after you have satisfied your Deductible. The annual dollar limit is called the Coinsurance limit. There is a Coinsurance limit on your medical Benefit but not on your prescription drug Benefit.

Coinsurance is a fixed percentage of the Maximum Allowed Amount for Covered Services which the Member is required to pay as specified in the Summary of Benefits.

Out-of-Pocket Limits

Out-of Pocket is specified dollar amount of expense incurred by a Member and/or family for Covered Services in a Benefit Period as listed on the Summary of Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-covered services. Refer to the Summary of Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached for a Member and/or family, then no additional Copayments, Deductibles and Coinsurance are required for that person and/or family unless otherwise specified in this Certificate and/or the Summary of Benefits.

Out- of- Pocket Limit(s) means the Copayments, Deductible and Coinsurance amounts which are paid by either one Member or a combination of Members of the family depending on your plan..

Changes in Subscription Charge

The Subscription Charge for this Certificate may change subject to, and as permitted by, applicable law. You will be notified of a Subscription Charge change at the address in Our records 30 days in advance of the final change in Subscription Charge. An increase in premium rates may not be implemented until the effective date or 60 days after notice of the proposed rate increase is given, whichever is later. Any such change will apply to Subscription Charges due on or after the Effective Date of change. If advance Subscription Charges have been paid beyond the Effective Date of a rate change, such Subscription Charge will be adjusted as of that Effective Date to comply with the rate change. Additional Subscription Charges may be billed, if necessary, for future periods.

Certificate Changes

We may change this Certificate at any time provided the changes have been approved by the Maine Bureau of Insurance, are in accordance with all applicable laws, and We send written notice 60 days in advance to the subscriber’s latest address in Our records. After We notify the Subscriber of a change, payment of billed charges indicates the acceptance of the change.

Compliance with Laws

If federal laws or the relevant laws of the state of Maine change, the provisions of this Certificate will automatically change to comply with those laws as of their effective dates. Any provision that does not conform with applicable federal laws or the relevant laws of the state of Maine will not be rendered invalid, but will be construed and applied as if it were in full compliance.

Confidentiality

Any information pertaining to your diagnosis, treatment or health obtained from either your physician, provider or you will be held in confidence. We may use or disclose this information only to the extent required or permitted by law. Please refer to Anthem's privacy protection annual notice for Our privacy policies and procedures.

Form or Content of Booklet

No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of Anthem.

Statements and Representations

The statements you make on your application for coverage with Us are representations and not warranties.

Annual Reports

Annual reports are prepared and made available to all employees. The annual report contains information about Our activities including audited financial statements.

Severability

If any term or provision in this Certificate is deemed invalid or unenforceable, this does not affect the validity or enforceability of any other term or provision.

Acknowledgement of Understanding

The Subscriber hereby expressly acknowledges its understanding that this policy constitutes a contract solely between Subscriber and Anthem Health Plans of Maine, Inc, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem to use the Blue Cross and/or Blue Shield Service Mark in the State of Maine, and that Anthem is not contracting as the agent of the Association. The Subscriber further acknowledge and agree that it has not entered into this policy based upon representations by any person other than Anthem and that no person, entity, or organization other than Anthem shall be held accountable or liable to the Subscriber for any of Anthem's obligations to the Subscriber created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

Benefit Payments

Claims Procedure

How to Claim Benefits

In most instances, Providers will file your claims with Us. However, you may need to submit a claim for reimbursement for services from Non-Network Providers.

To receive claim forms, please call Our Customer Service Department at the number on the back of your identification card. When you submit your claim, please include originals of all of your bills and retain a copy for your files. If such forms are not furnished before the expiration of 15 days after the insurer received notice of any claim under the policy, the person making such claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

Time Limit for Filing Claims

We must receive proof of a claim for reimbursement for a Covered Service no later than 365 days after that service is received. We recognize that there may be special circumstances which would prevent a claim from being submitted within the 365-day time limit. Claims denied for timely filing may be reviewed through the Member Appeal process, which will consider whether the claim was filed as soon as reasonably possible.

Releasing Necessary Information

Providers often have information We need to determine your coverage. As a condition for receiving benefits under this Certificate, you or your representative must give Us all of the medical information needed to determine your eligibility for coverage or to process your claim.

Non-Transfer of Benefits

Your benefits under this Certificate are personal to you. You cannot assign or transfer them to any other person.

Assignment of Payments

You may assign payment provided for Covered Services to the provider of the care.

Non-Compliance

If We do not enforce compliance with any provision of this Certificate, We have not waived compliance and are not required to allow non-compliance with that specific provision or any other provision at any time, in any case.

Examination of Insured

To ensure that all claims are valid, We may require the Member to have a physical or mental examination at Our expense.

Claims Payment

This section explains how benefits for Covered Services will be paid. Benefits will never be more than the actual charge. You will receive maximum benefits when you receive services from Network Providers. We reserve the right to pay benefits to another person if so ordered by a court of competent jurisdiction. You have the right to Appeal as outlined later in this section. A claim for payment of benefits under this Certificate is payable within 30 days after proof of loss is received by the insurer as long as the carrier has received all information need to pay or deny the claim.

Explanation and notice to Parent

If the insured is covered as a dependent child, and if the insurer is so requested by a parent of the insured, the insurer shall provide that parent with:

- Payment or denial of claim. An explanation of the payment or denial of any claim filed on behalf of the insured, except to the extent that the insured has the right to withhold consent and does not affirmatively consent to notifying the parent;
- Change in terms and conditions. An explanation of any proposed change in the terms and conditions of the policy; or
- Notice of lapse. Reasonable notice that the policy may lapse, but only if the parent has provided the insurer with the address at which the parent may be notified.

In addition, any parent who is able to provide the information necessary for the insurer to process a claim must be permitted to authorize the filing of any claims under the policy.

Payment of Provider Services

Maximum Allowed (Allowable) Amount (MAA)

General

Reimbursement for services rendered by Network and Non-Network Providers is based on the Maximum Allowed Amount for the Covered Service that you receive. Please see the “Inter-Plan Arrangements” section of this Certificate for additional information.

The Maximum Allowed Amount is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Benefit Program and are not excluded;
- that are Medically Necessary; and

- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Benefit Program.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

Generally, services received from an Non-Network Provider under this Certificate are not covered except for Emergency Care, or when allowed as a result of a Prior Authorization by Us. When you receive Covered Services from an Non-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It only means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

When multiple procedures are performed on the same day by the same Provider, or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Network Provider or a Non-Network Provider.

A Network Provider is a Provider who is in the managed network for this specific Benefit Program or in a special center of excellence/or other closely managed specialty network, or who has a participation contract with Us. For Covered Services performed by a Network Provider, the Maximum Allowed Amount is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Network Provider or visit Our website at www.anthem.com.

Providers who have not signed any contract with Us and are not in any of Our networks are Non-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from a Non-Network Provider that have been prior authorized by Us, the Maximum Allowed Amount will be one of the following as determined by Anthem:

1) An amount based on Our Non-Network Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar Providers, reimbursement amounts for like/similar Providers, reimbursement amounts paid by the Centers for Medicare and

Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or

2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or

3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or

4) An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.

5) An amount based on or derived from the total charges billed by the Non-Network Provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Non-Network. The Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Unlike Network Providers, Non-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding a Network Provider or visit Anthem's website at www.anthem.com.

Customer Service is also available to assist you in determining the Maximum Allowed Amount for a particular service from a Non-Network Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your out of pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

For certain Covered Services and depending on your Benefit Program, You may be required to pay a part of the Maximum Allowed Amount as your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

Anthem will not provide any reimbursement for non-Covered Services. You will be responsible for the total amount billed by your Provider for non Covered Services, regardless of whether such services are performed by a Network or Non-Network Provider. Both services specifically excluded by the terms of your Benefit Program, and those received after benefits have been exhausted are non-Covered Services. Benefits may be exhausted by exceeding, for example, your day/visit limits.

In some instances you may only be asked to pay the lower in-network Cost-Sharing amount when you use a Non-Network Provider. For example, if you go to a Network Hospital or Provider Facility and receive Covered Services from a Non-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or facility, you will pay the Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge.

Authorized Services

In some non-Emergency circumstances, such as where there is no Network Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from a Non-Network Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Network Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Network Provider and are not able to contact Anthem until after the covered service is rendered. If We authorize a Covered Service so that you are responsible for the Network Cost -Share amounts, you may still be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

You require the services of a specialty Provider; but there is no Network Provider for that specialty in your Local Network Area. You contact Anthem in advance of receiving any Covered Services, and We authorize You to go to an available Non-Network Provider for that Covered Service and We agree that the network Cost-Share will apply.

Your plan has a $25 Copayment for Network Providers for the Covered Service. The Non-Network Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the Network Cost Share amount to apply in this situation, you will be responsible for the Network Copayment of $25 and Anthem will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Non-Network Provider's charge for this service is $500, You may receive a bill from the Non-Network Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with Your Network Copayment of $25, Your total out of pocket expense would be $325.

Inter-Plan Arrangements

Out-of-area services

Anthem covers only limited healthcare services received outside of Our Service Area. For example, emergency or urgent care obtained out of the Anthem Service Area is always covered. Any other services will be covered only if authorized by your Primary Care Physician.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an "Inter-Plan Program"), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its Network Providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable Copayment, Coinsurance and/or Deductible stated in this Evidence of Coverage.

Whenever you obtain covered services or supplies outside BCBS Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Anthem's Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for emergency or urgent care, the charges for that care are covered. Anthem will only cover any other use of a non-participating, out-of-area Provider if that use is authorized by your Primary Care Physician. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Anthem's Service Area based on the Provider's billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment We would make if we were paying a non-participating Provider inside of Our Service Area. This could happen when the Host Blue's payment for the service would be more than Our payment for the service. Also, at Our discretion, We may negotiate a payment with such a Provider on an exception basis.

Coordination of Benefits

All payments for Covered Services under the Certificate are subject to coordination of benefits (COB). COB is a formula that determines how benefits are paid to Members covered by more than one contract. It helps keep down the cost of health coverage by ensuring that the total benefits you receive from all contracts do not exceed the cost of covered services.

COB sets the payment responsibilities for any contract that covers you, such as:

- Group, individual (also known as non-group), self-insured plans, franchise, or blanket insurance, including coverage through a school or other educational institution but excluding school accident type coverage;
- Group practice, individual practice, and other prepaid group coverage, labor-management trustee plan, union welfare plan, employer organization plan, or employee benefit organization plan; or

- Other insurance that provides medical benefits.

The contract with primary responsibility provides full benefits for Covered Services as if there were no other coverage. The contract with secondary responsibility may provide benefits for Covered Services in addition to those of the primary contract. When there are more than two contracts covering the person, the contract may be primary to one or more contracts, and may be secondary to another contract or contracts. All payments for Covered Services are limited to the Certificate maximums or to the Maximum Allowable Amount for the services you receive.

When you have duplicate coverage:

- If the other contract does not contain a COB clause or does not allow coordination of benefits with this Certificate, the benefits of that contract will be primary;
- If both contracts contain a COB clause allowing the coordination of benefits with this Certificate, We will determine benefit payments by using the first of the following rules that applies:

1. **Non-Dependent/Dependent** The benefits of the contract that covers you as an employee or Subscriber will be determined before the benefits of the contract that covers you as a dependent are determined.

2. **Dependent Children (Parents Not Legally Separated or Divorced)** For claims on covered dependent children, the contract of the parent whose birthday occurs first in the year will be primary. If both parents have the same birthday, the contract that has covered one parent longer will be primary over the contract that has covered the other parent for a shorter period. If the other contract does not include the rule described immediately above, but instead has a rule based on the gender of the parent, and as a result the contracts do not agree on the order of benefits, the rule in this Certificate will determine the order of benefits.

3. **Dependent Children (Parents Legally Separated or Divorced)** In the case of legal separation or divorce, the coverage of the parent with custody will be primary. If the parent with custody has remarried, coverage of the parent's spouse will be secondary, and the coverage of the parent without custody will be last. Whenever a court decree specifies the parent who is financially responsible for the dependent's health care expenses, the coverage of that parent's contract will be primary. If a court decree states that the parents have joint custody, without stating that one or the other parent is responsible for the health care expenses of the child, the order of benefits is determined by following rule two.

4. **Active/Inactive Employee** The benefits of a contract that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a contract that covers the person as a laid-off or retired employee (or as that employee's dependent). If the other coverage does not include this provision, and as a result, the contracts do not agree on the order of benefits, rule six applies.

5. **Continuation of Coverage** If a person whose coverage is provided under the right of continuation pursuant to a federal or state law is also covered by another contract, the benefits of the contract covering the person as an employee or subscriber, or as the dependent of an employee or subscriber, will be primary. The benefits of the continuation coverage will be secondary. If the other contract does not include this provision regarding continuation coverage, rule six applies.

6. **Longer/Shorter Length of Coverage** If none of the rules above determines the order of benefits, the benefits of the contract that has covered the employee or subscriber longer will be determined before those of the contract that has covered the person for a shorter period.

We reserve the right to:

- Take any action needed to carry out the terms of this section;

- Exchange information with an insurance company or other party;
- Recover the Plan's excess payment from another party or reimburse another party for its excess payment; and
- Take these actions when We decide they're necessary without notifying the covered persons.

Special Information If You Become Eligible For Medicare You must notify Us if you become eligible for premium free Medicare Part A. Failure to notify Us could result in retroactive benefit adjustments if Medicare would have been or is the primary payor. You may choose to continue your coverage once you are eligible for premium free Medicare Part A and Medicare Part B coverage. However, your Certificate will not provide benefits that duplicate any benefits payable under Medicare Part A or Part B. This is true even if you fail to exercise your rights to premium free Medicare Part A and Medicare Part B coverage. If you become eligible for Medicare, you may want to enroll in a Medicare Supplement Plan. Medicare Supplement plans are specifically designed to pay many of the health care costs not covered by Medicare. Because Medicare Supplement plans have limited enrollment periods, it is important to evaluate these plans as soon as you are eligible for Medicare.

Subrogation: Payments Resulting from Claim or Legal Action

When another party may have caused or may be responsible for your injury or illness, you may be entitled to payment from a claim or legal action against that party. When We provide health care benefits for treatment of your injury or illness, We have the right to recover, from any such payment (whether by judgment, suit, compromise, settlement or otherwise) up to the total benefit We paid, on a just and equitable basis. The process of recovering these expenses is called subrogation.

We also have subrogation rights against your own insurance, including medical payments, uninsured, and underinsured motorist provisions in your auto insurance policy.

Subrogation applies whether any of the payment or settlement is allocated for medical expenses.

If the services related to your illness or injury are covered by a capitation fee, We are entitled to the reasonable cash value of the services.

By accepting plan coverage you agree:

- Your signed application for coverage is your authorization of Our right of subrogation;
- To notify Us of any event which could result in legal action, a claim against a third party, or a claim against your own insurance;
- To notify Us of any payments you receive as a result of legal action, a claim against a third party, or a claim against your own insurance;
- To cooperate with Us in exercising Our right of subrogation by providing all information requested;
- To sign documents We deem necessary to protect Our rights; and
- To do nothing to interfere with Our subrogation rights.

If you do not comply with the above, you may be responsible for expenses We incur in enforcing Our subrogation rights.

Workers' Compensation

We do not provide Benefits for any condition, ailment, or injury that arises out of and in the course of employment or any disability that develops because of an occupational disease. We do not provide Benefits for services or supplies, to the extent that they are obtained, either completely or partially, under

any Workers' Compensation Act or similar law, or would be obtainable under these laws but for a waiver or failure to assert your rights under these laws. However, we do provide Benefits if you are entitled under the applicable workers' compensation law to waive all workers' compensation coverage, and do so before the condition, ailment, or injury occurs. We will pay Benefits on a provisional basis for treatment of a contested work-related condition, ailment, or injury only if all the following conditions are met:

- You are making a claim under the Workers' Compensation Act;
- Your health care coverage is provided through an employee health plan;
- Your employer or your employer's workers' compensation insurer has filed a notice of controversy stating that your claim is being denied for work-relatedness;
- The Workers' Compensation Board has not made a determination on your claim;
- Your employer has made no payment on or settlement of your claim.

Even though you may be submitting a claim under the Workers' Compensation Act, you should also submit your claims under this plan, as discussed in the "Benefit Determinations, Payments and Appeals" section

Credit toward deductible

When an insured is covered under more than one expense-incurred health plan, payments made by the primary plan, payments made by the insured and payments made from a health savings account or similar fund for benefits covered under the secondary plan must be credited toward the Deductible of the secondary plan. This subsection does not apply if the secondary plan is designed to supplement the primary plan.

Complaints and Appeals

Complaints

Our Customer Service Representatives are ready to help Members resolve complaints about claims processing, benefit choices, enrollment, or health care given to you by your Provider. A Customer Service Representative may need to send your complaint to another area for response. The staff that gets the Member complaint will review and quickly give a finding to the Member on the complaint. Anthem will make a good faith effort to get all information quickly. Your Provider may ask by phone, fax or in writing for Us to reconsider an Adverse Determination within one working day after We get the request. The review will be done by the person who made the Adverse Determination or by a peer if the first person cannot be on hand within one working day.

For first Utilization Review findings, Anthem will make the decision and will let the Covered Person and their Provider know the result within 2 working days after getting all needed information on a proposed hospital stay, treatment or service that calls for a review decision.

If your complaint is not resolved to your satisfaction, you may seek help through the Appeal process outlined below. Enrollees may begin a first level Appeal at any time.

Complaints Requiring Immediate Intervention

If you are not happy with a finding on a service, We will work with the health care provider to answer quickly to the concern. This will happen before the need for services, when possible, or within 48 hours after receiving all necessary information.

Concurrent review decisions. Anthem will make the decision within one working day after getting all needed information.

In the case of a decision to approve a longer stay or more services, Anthem notifies the Member and the Provider rendering the service within one working day. The written notice will include the number of

added days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

In the case of an Adverse Determination, Anthem notifies the Member and the Provider rendering the service within one working day. The service will continue without liability to the Member until the Member has been told of the finding.

Expedited Appeals. Anthem has a written process for the expedited review of an Adverse Determination involving a situation where the time frame of the standard review procedures would seriously threaten the life or health of a Member or would risk the Member's ability to get back maximum function. An expedited appeal will be available to, and may be requested by, the Member or the Provider acting for the Member.

Expedited appeals will be reviewed by a clinical peer or peers. The clinical peer/s will not have been part of the first Adverse Determination.

Anthem will provide expedited review to all requests for a hospital stay, availability of care, continued stay or health care service for a Member who has received emergency services but has not been discharged from a facility.

In an expedited review, all needed information, including Anthem finding, will be shared between Anthem and the Member or the Provider acting for the covered person by telephone, facsimile, electronic means or the quickest method available.

In an expedited review, Anthem will make a decision and notify the Member and the Provider acting for the Member by phone as quickly as the Member's medical condition requires, but not more than 72 hours after the review is begun. If the expedited review is a concurrent review decision of emergency services or of an initially authorized hospital stay or course of treatment, the service will be continued without liability to the Member until the Member has been notified of the finding.

If the first notice was not in writing, Anthem will confirm its finding about the expedited review in writing within 2 working days of providing notice of that finding.

Appeals

Level One Appeal Process

You or your authorized representative, if not satisfied with the first decision or the finding on a complaint, may Appeal the decision to the Anthem Appeals Department. An Appeal may be done orally or in writing and must include specific reasons why you or your representative do not agree with the finding. Appeal of a finding must be sent to within one-hundred-eighty (180) calendar days of the date the finding was made, unless there are special circumstances. We have the right to review the reason for the delay and find out whether they warrant acceptance of the Level One Appeal past the 180-day time frame.

On Appeal, the file will be reviewed. Appeals will be reviewed by an appropriate peer or peers who have not been involved with a prior finding. More information may be submitted by or for the Member, any treating physician, or Anthem. A finding will be made within thirty (30) days after We receive the request for an Appeal.

The decision will include:

- The names, titles and information that qualifies the person or persons evaluating the appeal;
- A statement of the reviewers' understanding of the reason for the Covered Person's request for an Appeal;
- The reviewers' finding in clear terms and the reason in enough detail for the Covered Person to respond to the health carrier's finding;
- A reference to the evidence or information used as the basis for the finding, including the clinical review materials used to make the decision. The finding shall include instructions for requesting copies of any referenced evidence, documents or clinical review information not already provided to the Member. Where a Member had already sent in a written request for the review criteria used by Anthem in giving its first Adverse

Determination, the finding shall include copies of any additional clinical review criteria used in arriving at the decision.

- The notice must advise of any additional appeal rights, and the process and time limit for exercising those rights. Notice of external review rights must be provided to the Enrollee and a description of the process for sending in a written request for second level grievance review.

When the finding is made, if the Member, or Member representative, does not agree with the finding, they may submit a voluntary second level Appeal to Anthem, request an external review, file a complaint with the Bureau of Insurance and/or bring legal action against Anthem. The Superintendent of Insurance may be contacted toll-free at 1-800-300-5000.

If you choose to request a voluntary second level Appeal, you may meet with the review panel in person, or at Anthem's expense by conference call, video conferencing or other appropriate technology to present your concerns with Our Adverse Determination.

Voluntary Level Two Appeal, You may request a voluntary level two appeal or go straight to an external appeal.

On a Level Two Appeal, the entire record will be reviewed.

Appeals of a clinical nature will be reviewed by an appropriate peer or peers who have not been involved with the prior finding. Additional information may be sent in by or for the Member, any treating Physician, or Anthem. You or your representative may meet with the review panel. If you do not request to meet in person, the decision for second level grievance reviews will be made within 30 calendar days. If you do request to appear in person, the review will be done within forty-five (45) days after We receive the Member's Level Two Appeal. A written decision will be sent to the Member within five (5) working days of the review. Once a final decision has been made by the Second Level Appeal panel, the Member may then ask for an external review, file a complaint with the Bureau of Insurance and/or bring legal action against Anthem.

In any Appeal under this procedure in which a professional medical opinion about a health condition is an issue, you may have the right to an independent second opinion, of a provider of the same specialty, paid for by the plan.

Upon the request of a Member, Anthem shall provide to the Member all information that was used for that finding that is not confidential or privileged.

A Member has the right to:

- Attend the second level review;
- State his or her case to the review panel;
- Submit added material both before and at the review meeting;
- Ask questions of any employee in the meeting; and
- Be assisted or represented by a person of his or her choice.

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[Optional Language]

External Review Process

Your representative is a person who has your written consent to represent you in an external review; a person authorized by law to give consent to request an external review for you; or a family member or your treating physician when you are unable to provide consent to request an external review.

If you, or your representative, do not agree with the outcome of the Level One or Voluntary Level Two Appeal on an Adverse Health Care Treatment Decision by Anthem, you may make a written request for external review to the Bureau of Insurance. A health care treatment decision involves issues of medical necessity, preexisting condition findings and findings regarding experimental or investigational services. An Adverse Health Care Treatment Decision is a decision made by Us or on Our behalf denying

payment. The request must be made within 12 months of the date the Member has received the final Adverse Health Care Treatment Decision of the Level One or Voluntary Level Two Appeal panel.

You or your representative may not request an external review until you have completed Level One of the internal Appeals process unless:

- Anthem did not make a decision on an Appeal within the time period required or has failed to follow all the requirements of the appeal process as state and federal law require, or the Member has asked for an expedited external review at the same time as applying for an expedited internal appeal;
- Anthem and you both agree to bypass the internal Appeals process;
- The life or health of the Member is at risk;
- The Member has died; or
- The Adverse Health Care Treatment Decision to be reviewed concerns an admission, availability of care, a continued stay or health care services when the claimant has received emergency services but has not been discharged from the facility that provided the emergency services.

The Bureau of Insurance will oversee the external review process. Except as stated below, a written finding must be made by the independent review organization within thirty (30) days after receipt of a completed request for external review from the Bureau of Insurance.

Expedited External Review. An external review finding must be made as quickly as a Member's medical condition requires but no more than 72 hours after the completed request for external review is received if the 30-day time frame above would risk the life or health of the Member or would put the Member's ability to get back maximum function at risk.

An external review finding is binding on Anthem. You, or your representative, may not file a request for a second external review involving the same Adverse Health Care Treatment Decision for which you have already received an external review decision.

Legal Action Against Anthem

No legal action may be brought against Anthem until the Member or the Member's authorized representative has exhausted the complaint and Appeals process outlined above. Any action must be initiated within three (3) years from the earlier of:

- The date of issuance of the written external review decision; or
- The date of issuance of the underlying adverse Level One Appeal decision or the Level One grievance determination notice.

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[Optional Language]
OPM MSP External Review language:

If you do not agree with our decision, you are entitled to request an independent, external review of our decision. Contact the U.S. Office of Personnel Management (OPM) at (855) 318-0714 with any questions about your right to request external review. You may file a request online by visiting www.opm.gov/healthcare-insurance/multi-state-plan-program/. You can also send a written request to:

MSPP External Review
National Healthcare Operations
U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415

You or someone you name to act for you (your authorized representative) may file a request for external review. You may authorize someone to file on your behalf by naming them in your request.

All requests for external review will be handled as quickly as possible. However, if your situation is urgent, your request will be handled within 72 hours of its receipt. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your provider; you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. You may request an expedited external review by sending an attestation from your doctor with your request for external review.

If you file a request for external review, OPM will review our decision. If your claim was denied as not medically necessary, OPM will seek the binding opinion of an independent review organization (IRO). If your claim was denied based on the terms of coverage under this plan, OPM will render a binding determination. If either the independent review organization or OPM decides to overturn our decision, we will provide coverage or payment for your health care item or service.

After you have filed your request for external review, you will receive instructions on how to supply additional information.

For questions about your rights, or for assistance, you can contact OPM at (855) 318-0714. Additionally, a representative of the Consumer Health Care Division of the Maine Bureau of Insurance can help you file your appeal. Contact the Consumer Health Care Division at 1-800-300-5000 or write to them at Consumer Health Care Division, Maine Bureau of Insurance, 34 State House Station, Augusta, Maine 04333.

Legal Action Against Anthem

No legal action may be brought against Anthem until the Member or the Member's authorized representative has exhausted the complaint and Appeals process outlined above. Any action must be initiated within three (3) years from the earlier of:

- The date of issuance of the written external review decision; or
- The date of issuance of the underlying adverse Level One Appeal decision or the Level One grievance determination notice.

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Section Six - Definitions

This section explains the meaning of some of the words in Certificate. Other words may be defined in the text.

Accident Care Treatment of an accidental bodily injury sustained by the Member that is the direct cause of the condition for which payments for Covered Services are provided and that occurs while the insurance is in force.

Advance Payments of the Premium Tax Credit (APTC) Payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

Ambulatory Surgical Facility A facility that meets both of the following requirements:

- Licensed as an ambulatory surgery center, or is Medicare certified; and
- Meets Our standards for participation.

Amendment An addition, change, correction, or revision to the terms and conditions of this Contract.

American Indian An individual who is a member of a Federally Recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

Annual Out-of-Pocket Limit The limit on the Deductible and Coinsurance you pay each year. After you meet the annual out-of-pocket limit, you pay no further Deductible or Coinsurance for most services.

Anthem Blue Cross and Blue Shield (Anthem) The company providing the coverage under this Certificate. The terms We, Us and Our in this Certificate refer to Anthem and its designated affiliates.

Appeal A request for a review of Our initial decision, a decision on a registered complaint, or determination of medical necessity.

Applied Behavior Analysis The design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Autism Spectrum Disorder Any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

Balance Billing When a Provider bills you for the difference between the Provider's charge and the Maximum Allowed Amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Benefit Year A Calendar Year for which a health plan provides coverage for health benefits.

Brand Name Drugs Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Calendar Year The period starting on the effective date of your coverage and ending on December 31 of that year or the date your coverage ends, whichever occurs first. Each succeeding Calendar Year starts on January 1 and ends on December 31 of that year or the date your coverage ends, whichever occurs first.

Certificate of Coverage (Certificate) The document that specifies the health care Benefits available to Members under this Certificate.

Chiropractor A person who is licensed to perform chiropractic services, including manipulation of the spine.

Coinsurance The percentage paid toward the cost of some Covered Services.

Community Mental Health Center An institution that meets both of the following requirements:

- Licensed as a comprehensive level community mental health center; and
- Meets Our standards for participation.

Co-payment A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cosmetic Services Medical/surgical procedures or services intended solely to change or improve appearance or to treat emotional, psychiatric, or psychological conditions.

Cost-Share The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Share can be in the form of Copayments, Coinsurance and/or Deductibles.

Covered Service Services, supplies or treatment as described in this Certificate. To be a Covered Service the service, supply or treatment must be:

a. Medically Necessary Health Care or otherwise specifically included as a benefit under this Certificate.
b. Within the scope of the license of the Provider performing the service.
c. Rendered while coverage under this Certificate is in force.
d. Not experimental or investigational or otherwise excluded or limited by this Certificate, or by any amendment or rider thereto.
e. Authorized in advance by Us if such preauthorization is required in Certificate.

Creditable Coverage includes group or individual health insurance, Medicare, Medicaid, CHAMPUS, Indian Health Care Improvement Act, state health benefit risk pool, federal employees health benefit plan, qualified public health plan, the Peace Corps health benefit plan, S-CHIP, or a qualified foreign health plan.

Custodial Care Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs, and which is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- Assistance with walking, bathing, or dressing;
- Transfer or positioning in bed;

- Normally self-administered medicine;
- Meal preparation;
- Feeding by utensil, tube, or gastrostomy;
- Oral hygiene;
- Ordinary skin and nail care;
- Catheter care;
- Suctioning;
- Using the toilet;
- Enemas; and
- Preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial whether or not it is recommended or performed by a professional and whether or not it is performed in a facility (e.g. hospital or skilled nursing facility) or at home.

Day Treatment Patient A patient receiving mental health or substance abuse care on an individual or group basis for more than two hours but less than 24 hours per day in either a hospital, rural mental health center, substance abuse treatment facility, or community health center. This type of care is also called partial hospitalization.

Deductible The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Dental Service Items and services provided in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth. Structures directly supporting the teeth include: the periodontium, which includes the gingiva, dentogingival junction, cementum (the outer surface of a tooth root), alveolar process (the laminar dura, or tooth socket, and supporting bone), and the periodontal membrane (the connective tissue between the cementum and the alveolar process).

Dependent The eligible Subscribers lawful spouse, children and others as outlined in the "Eligibility and Termination of Coverage" section of this Certificate.

Diagnostic Service A service performed to diagnose specific signs or symptoms of an illness or injury, such as: x-ray exams (other than teeth), laboratory tests, cardiographic tests, pathology services, radioisotope scanning, ultrasonic scanning, and certain other methods of diagnosing medical problems.

Discount Favorable rates or discounts We have negotiated with hospitals and other providers. Members benefit from these rates or discounts since they are applied prior to calculating your share of costs. Discounted charges reduce the expenses paid by Us which helps to lower the contract costs.

Domiciliary Care Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Durable Medical Equipment (DME) Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Early Intervention Services Services provided by licensed occupational therapists, physical therapists, speech-language pathologist or clinical social workers working with children from birth to 36 months of age with an identified developmental disability or delay as described in the federal Individuals with Disabilities Education Act.

Effective Date The first day of coverage with Anthem Blue Cross and Blue Shield

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2) Serious impairment to bodily functions; or
3) Serious dysfunction of any bodily organ or part.

Emergency Service (Emergency Room Care) means, with respect to an emergency medical condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and
2) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

Experimental or Investigational Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which Anthem determines to be experimental or investigational.

Anthem will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be experimental or investigational if it determines that one or more of the following criteria apply when the service is rendered with respect to the use for which payment of benefits are sought.

1) The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

    - Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other state or federal regulatory agency and such final approval has not been granted; or
    - Has been determined by the FDA to be contraindicated for the specific use; or
    - Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply, unless otherwise required by law; or
    - Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
    - Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as experimental or investigational or otherwise indicate that the safety, toxicity, or efficacy of

the drug, biologic, device, diagnostic, product equipment, procedure, treatment, service, or supply is under evaluation.

2) Any service not deemed experimental or investigational based on the criteria in subsection (a) may still be deemed to be experimental or investigational by Anthem. In determining whether a service is experimental or investigational, Anthem will consider the information described in subsection (c) and assess the following:

- Whether the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- Whether the evidence demonstrates the service improves the net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- Whether the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

3) The information considered or evaluated by Anthem to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is experimental or investigational under subsections (a) and (b) may include one or more items from the following list which is not all inclusive:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Documents of an IRB or other similar body performing substantially the same function; or
- Consent document(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- The written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Medical records; or
- The opinions of consulting providers and other experts in the field.

4) Anthem identifies and weighs all information and determines all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is experimental or investigational.

Family Planning Agency An agency that meets both of the following requirements:

- Is a delegated family planning agency under Title X of the Public Health Service Act and is in good standing with all applicable state and federal regulatory bodies; and
- Meets Our standards for participation.

Federally Eligible Individual To qualify as a Federally Eligible Individual, you must meet **all** of the following criteria:

- You must have had 18 months of continuous creditable coverage through one or more health plans, with no break in coverage exceeding 63 days.
- Your most recent prior creditable coverage must have been in effect within 63 days of applying for this insurance coverage.
- Your most recent prior creditable coverage must have been a group, government or church health plan.
- You must not qualify for any group health plan or government program, such as Medicare or Medicaid.
- Your most recent prior creditable coverage must not have been terminated because of nonpayment of premiums, fraud or intentional misrepresentation of a material fact.
- If offered COBRA, you must have elected and exhausted COBRA benefits.

Formulary Listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This formulary contains a limited number of prescription drugs, and may be different than the formulary for other Anthem products. Generally, it includes select generic drugs with limited brand prescription drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete prescription drugs from this formulary from time to time. A description of the prescription drugs that are listed on this formulary is available upon request and at www.anthem.com

Freestanding Imaging Center An institution that meets both of the following requirements:

- Licensed (where available) as a freestanding imaging center, freestanding diagnostic center, or freestanding radiology center; and
- Meets Our standards for participation.

Freestanding Surgical Facility An institution that meets all of the following requirements:

- Has a medical staff of physicians, nurses and licensed anesthesiologists;
- Maintains at least two operating rooms and one recovery room, as well as diagnostic laboratory and x-ray facilities;
- Has equipment for emergency care;
- Has a blood supply;
- Maintains medical records;
- Has agreements with hospitals for immediate acceptance of patients who need hospital confinement on an inpatient basis;
- Is licensed in accordance with the law of the appropriate legally authorized agency; and
- Meets Our standards for participation.

Generic Drugs The PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Home Health Agency An institution that meets both of the following requirements:

- Licensed as a home health agency; and
- Meets Our standards for participation.

Hospice A facility that meets both of the following requirements:

- Licensed as a hospice; and
- Meets Our standards for participation.

Hospice Care A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Hospital An institution that is duly licensed by the state of Maine as an acute care, rehabilitation or psychiatric hospital and is certified to participate in the Medicare program under Title XVIII of the Social Security Act.

Inborn Error of Metabolism A genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life.

Independent Laboratory An institution that meets both of the following requirements:

- Licensed as an independent medical laboratory; and
- Meets our standards for participation.

Infertility The inability to conceive a pregnancy after a year or more of regular sexual relations without contraception or the presence of a demonstrated condition recognized as a cause of infertility by the American College of Obstetrics and Gynecology, the American Urologic Association, or other appropriate independent professional associations.

Inpatient A registered bed patient who occupies a bed in a hospital, skilled nursing facility, or residential treatment facility. A patient who is kept overnight in a hospital solely for observation is not considered a registered inpatient. This is true even though the patient uses a bed. In this case, the patient is considered an outpatient.

Inpatient Stay One period of continuous, inpatient confinement. An inpatient stay ends when you are discharged from the facility in which you were originally confined. However, a transfer from one acute care hospital to another acute care hospital as an inpatient when medically necessary is part of the same stay.

Maintenance Medication iA Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maintenance Therapy Any treatment, service, or therapy that preserves the Member's level of function and prevents regression of that function. Maintenance therapy begins when therapeutic goals of a treatment plan have been achieved or when no further functional progress is apparent or expected to occur.

Maximum Allowed Amount (MAA) The maximum amount that we will allow for Covered Services you receive. For more information, see the "Benefit Determinations, Payments and Appeals" section.

Medicaid Title XIX of the United States Social Security Act, Grants to States for Medical Assistance Programs.

Medically Necessary Health Care Health care services or products provided to a Member for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

- Consistent with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Demonstrated through scientific evidence to be effective in improving health outcomes;
- Representative of "best practices" in the medical profession; and
- Not primarily for the convenience of the Member or physician or other health care practitioner.

Medicare The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Member The subscriber and all family members who are eligible for coverage and who We accept for coverage under this Contract.

Mental Health Service A service to treat any disorder that affects the mind or behavior regardless of origin.

Minimum Essential Coverage Any of the following: Government sponsored programs Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of HHS recognizes.

Morbid Obesity A condition of persistent and uncontrolled weight gain existing for a minimum of five consecutive years that constitutes a present or potential threat to life. This is characterized by weight that is at least 100 pounds over or twice the weight for frame, age, height, and sex in the most recently published Metropolitan Life Insurance table.

Network Providers Health care Providers that have a written agreement with Anthem to furnish health care services under this Contract. Also referred to as participating Providers.

Non-Network Providers Health care Providers that do not have a written agreement with Anthem to furnish health care services under this Contract. Also referred to as non-participating Providers. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this plan are also considered Non-Network Providers .

Non-Participating Pharmacy A Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most

instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Orthognathic Surgery A branch of oral surgery dealing with the cause and surgical treatment of malposition of the bones of the jaw and occasionally other facial bones.

Orthotic Device A device that restricts, eliminates, or redirects motion of a weak or diseased body part.

Outpatient A patient who receives services at a provider and who is not a registered inpatient or a day treatment patient. A patient who is kept overnight in a hospital solely for observation is considered an outpatient. This is true even though the patient uses a bed.

Participating Pharmacy A Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Process Process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for Our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Physician See definition of “Provider.”

Plan Year A consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Prescription Drug (Drug) A medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes insulin, diabetic supplies, and syringes.

Primary Care Physician (PCP) A Physician, qualified Certified Nurse Practitioner, or other qualified Provider, as required by law, within the Network whom the Member has designated as his or her primary care physician, and who is normally engaged in one of the following categories of practice; family practice, internal medicine, pediatrics or obstetric/gynecology.

Prostheses Prostheses are appliances that replace all or part of a body organ (including contiguous tissue) or replace all or a part of the function of a permanently inoperative, absent, or malfunctioning body part.

Provider (Physician, Doctor) A licensed health care institution, facility, agency, or an independently billing, licensed health care specialist acting within the scope of his or her license. Only the following Providers are eligible for payment under this Contract:

- Acute-care Hospitals

- Skilled nursing facilities
- Rural Health Centers
- Home health agencies
- Ambulatory surgery centers
- Hospices
- Community Mental Health Centers
- Substance Abuse Treatment Facilities
- Licensed pharmacies
- Acute care psychiatric and rehabilitation Hospitals
- Independent laboratories
- Freestanding Imaging Centers
- Family planning agencies
- Durable Medical Equipment Providers
- Home infusion Providers
- Other Providers that have written participating agreements with Us;
- Other Providers, as required by law.

Physicians

- Doctor of Medicine
- Doctor of Osteopathy

Other Professionals

- Doctor of Optometry
- Doctor of Chiropractic
- Doctor of Podiatry
- Doctor of Dentistry
- Doctor of Psychology
- Independent Practice Dental Hygienist
- Licensed Audiologist
- Licensed Psychiatric Nurse Specialist
- Licensed Clinical Social Worker
- Licensed Clinical Professional Counselor

- Licensed Marriage and Family Therapist
- Licensed Pastoral Counselor
- Physical Therapist
- Occupational Therapist
- Speech Therapist
- Registered Nurse
- Licensed Practical Nurse
- Certified Nurse Midwife
- Ambulance Services
- Other Professionals that have written participating agreements with Us;
- Other Professionals as required by law.

Qualified Health Plan or QHP A health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer (QHP Issuer) A health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual With respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Radiation Therapy The use of high energy penetrating rays to treat an illness or disease.

Reconstructive Procedures Procedures performed on structures of the body to improve or restore bodily function or to correct deformity when there is functional impairment resulting from disease, trauma, previous therapeutic process, or congenital or developmental anomalies.

Rural Health Center An institution that meets both of the following requirements:

- Certified by the Department of Human Services under the United States Rural Health Clinic Services Act; and
- Meets Our standards for participation.

Self-Administered injectable Drugs Drugs that are injected which do not require a medical professional to administer.

Sitter/Companion A person who provides short-term supervision of hospice patients during the temporary absence of family members.

Skilled Nursing Facility (SNF) An institution that meets all of the following requirements:

- Licensed as a skilled nursing facility;
- Accredited in whole or in a specific part as a skilled nursing facility for the treatment and care of inpatients;

- Engaged mainly in providing skilled nursing care under the supervision of a physician in addition to providing room and board;
- Provides 24-hour-per-day nursing care by or under the supervision of a registered nurse (RN);
- Maintains a daily medical record for each patient;
- Is a freestanding unit or a designated unit of another licensed health care facility; and
- Meets Our standards for participation.

Specialist Service A service by a professional practicing in specialty areas such as cardiology, neurology, surgery, and other specialties.

Specialty Drugs Drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Stabilize means, with respect to an Emergency Medical Condition: To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

State Each of the 50 States and the District of Columbia.

Subcontractor An organization or entity that provides particular services in specialized areas of expertise. Examples of subcontractors include, but are not limited to, prescription drugs, mental health/ behavioral health and substance abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on our behalf.

Subscriber The person who applied for coverage under this Contract and whose application and payment of required subscription charges We have accepted.

Subscription Charge The rates established by Us as consideration for payment of Covered Services under this Contract.

Substance Abuse The misuse, excessive use, or improper use of alcohol or drugs to the extent that such use contributes to physical, mental, or social dysfunction, regardless of origin.

Substance Abuse Treatment Facility A residential or nonresidential institution that meets all of the following requirements:

- Licensed or certified as a substance abuse treatment facility;
- Provides care to one or more patients for alcoholism and/or drug dependency;
- Is a freestanding unit or a designated unit of another licensed health care facility; and
- Meets Our standards for participation.

Surgical Assistant A physician (Doctor of Medicine or Osteopathy) or dentist (Doctor of Dental Medicine or Dental Surgery), or other qualified professionals as permitted by law and recognized by Us who actively assists the operating surgeon in performing a covered surgical service.

Surgical Service A service performed by a professional acting within the scope of his or her license that is:

- A generally accepted operative and cutting procedure;
- An endoscopic examination or other invasive procedure using specialized instruments; or
- The correction of fractures and dislocations.

Tax Dependent Tax Dependent has the same meaning as the term dependent under the Internal Revenue Code.

Tax Filer Tax Filer means an individual, or a married couple, who indicates that he, she or they expect.

1. To file an income tax return for the Benefit Year
2. If married, per IRS guidelines, to file a joint tax return for the Benefit Year;
3. That no other taxpayer will be able to claim him, her or them as a tax dependent for the Benefit Year; and
4. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

Telemedicine The use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment. Telemedicine does not include the use of audio-only telephone, facsimile machine, or e-mail.

Terminal Illness A terminal illness exists if a person becomes ill with a prognosis of 12 months or less to live, as diagnosed by a physician.

Tier One Drugs This tier includes low cost and preferred Drugs that may be Generic, single-source Brand Drugs, or multi-source Brand Drugs.

Tier Two Drugs This tier includes preferred Drugs considered Generic, single source Brand Drugs, or multi-source Brand Drugs.

Tier Three Drugs This tier includes Drugs considered Generic, single-source Brand drugs, or multi-source Brand Drugs.

Tier Four Drugs This tier contains high cost Drugs. This includes Drugs considered Generic, single source Brand Drugs, and multi-source Brand Drugs. This tier also contains Specialty Drugs.

Treatment of Autism Spectrum Disorders The following types of care prescribed, provided or ordered for an individual diagnosed with autism spectrum disorder:

Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an individual to the extent possible. To be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;

1) Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker; and
2) Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist.

Utilization Management The process We use to determine the medical necessity, appropriateness, efficacy or efficiency of health care services. Techniques include inpatient admission

review, continued inpatient stay review, discharge planning, post admission review and case management.

We, Us, and Our The terms We, Us and Our in this Contract refer to Anthem Blue Cross and Blue Shield (Anthem) and its designated affiliates.